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Montana State Plan For Alcoholism And Alcohol Abuse FY 1976

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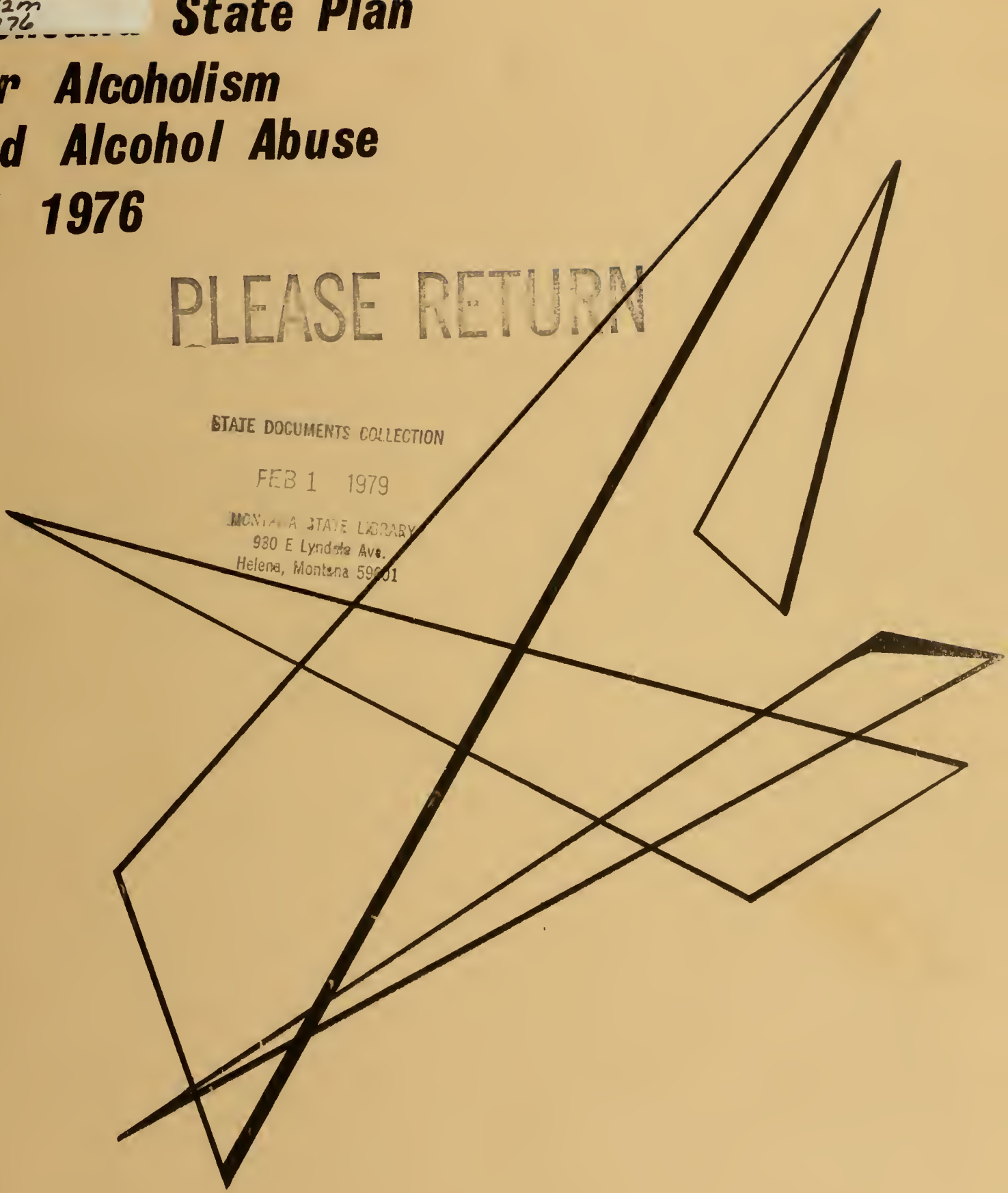

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MONTANA STATE PLAN FOR ALCOHOL ABUSE AND ALCOHOLISM PREVENTION, TREATMENT AND REHABILITATION PROGRAMS

PREFACE

THE MONTANA STATE PLAN PRESENTS A COORDINATED, COMPREHENSIVE PROGRAM FOR THE ORDERLY DEVELOPMENT AND IMPLEMENTATION OF NEEDED ALCOHOLISM PREVENTION, TREATMENT AND REHABILITATION PROGRAMS FOR THE ENTIRE STATE OF MONTANA.

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SECTION 1

1.1 INTRODUCTION

1.2 PURPOSE

1.3 ESTIMATED NUMBER OF ALCOHOLICS IN MONTANA

1.4 REGIONAL CONCEPT OF SERVICE DELIVERY

1.5 MINORITY REPRESENTATION STATEMENT

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MONTANA STATE PLAN FY 76

INTRODUCTION

The following Montana State Plan for Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation is presented toward fulfilling the requirements of the comprehensive alcohol abuse and alcoholism prevention treatment and rehabilitation act of 1970 (P.L. 91-616) and as amended by Public Law 93-282. The Montana State Plan is a public document that presents a coordinated comprehensive program for the orderly development and implementation of needed alcoholism prevention, treatment and rehabilitation programs for the entire State of Montana.

It serves as a basis for the allocation of formula grant funds and provides the rationale and effective basis for the utilization of federal, state and all other available resources in planning and establishing, maintaining, coordinating and evaluating prevention, treatment and rehabilitation projects and programs to deal with alcohol abusers and alcoholism in the State of Montana. This State Plan will facilitate the acquisition of necessary funds, assist in gaining other types of needed support, allow the state and localities to set appropriate and realistic goals and priorities, provide a useful tool for evaluation, assist in community education and contribute to total state growth and development.

COORDINATION WITH OTHER STATE AGENCIES

Many state agencies have responsibility for certain aspects of the total alcoholism service delivery system. The Department of Institutions has the major role but other state departments have specific functions.

Working relationships have been developed with the Department of Health and Environmental Sciences, Social and Rehabilitative Services, the Department of Community Affairs, the Department of Justice, and the Department of Public Instruction.

The coordination of effort between the several state agencies is viewed by the Single State Alcoholism Authority as an on-going and continuous process. Efforts are made, whenever possible, to involve other departments in the development of services and the delivery to the alcoholics and alcohol abusers in the communities.

The state agencies of Montana are continuing to adjust their coordination with other agencies as a result of the Executive Reorganization. This reorganization, that has been implemented, has altered the existing relationships between state departments and most state departments are still working toward a total and complete readjustment. The duties and functions of the departments have changed and as a result, the coordination that has existed for years is currently being restructured.

Coordination of all alcoholism services is viewed as a long term function that involves many of the state departments. This department

intends to create every opportunity for meaningful involvement of every other state department having a role or function in the delivery of services to the alcoholic or alcohol abuser throughout the state.

We also have a continuing effort to coordinate with the federal agencies having a role or function in the alcoholism service delivery system operating in Montana.

MONTANA STATE PLAN FY 76

PURPOSE

Under delegated authority from the director, Department of Institutions, the Bureau of Addictive Diseases will act as the Single State Authority for programs of alcoholism with that responsibility the Addictive Diseases Bureau will: 1. review, evaluate, and coordinate all federal and state funding proposals relating to alcohol abuse, 2. develop and review annually a State Plan for Alcoholism with all programs reviewed in terms of regional plan and this State Plan. All efforts and programs of the Bureau will encourage the development of coordinated community regional and statewide programs with the broadest possible citizen involvement.

Public and private support will be sought so that the Bureau's role will be that of initiator and catalyst rather than that of the maintainer of programs.

The Plan follows the guidelines for the preparation of State Plans which was submitted to us by W. Claude Reeder and received in 1972.

MONTANA STATE PLAN FY 76

ALCOHOLICS IN MONTANA

Estimates of the number of alcoholics in the general population vary between the several sources of information. Dr. Morris Chafetz, Director of the National Institute on Alcohol Abuse and Alcoholism, uses the figure of five percent of the general population. This would indicate that there are some 34,720 alcoholics in Montana. He also indicates that the incidence of alcoholism among Indians varies from ten percent to fifty percent. Montana has seven Indian reservations that together constitute 4.2 percent of the state population. A projected figure of Indian alcoholism in Montana would substantially increase the State total of alcoholic persons. The Social Research Group at George Washington University uses a figure of 8.15 percent of the general population. This would show 56,663. They do not make special reference to Indians.

All of the indications of alcohol consumption, alcohol related accidents, and other indicators are apparently showing increases; for example, the per capita consumption in Montana is showing an annual increase and at that is only surpassed by three other states. As a result, the percentage of alcoholics in Montana would be substantially higher than the 8.15% figure used for the general population by the Social Research Group. Because of this, we have projected the 8.15% figure upward to 8.50% for planning purposes. This then gives the following estimates:

8.5% of population (except Indian)	57,902
50% of Indian Population	13,565
Total	71,467
Ripple effect, others affected	285,868

The number of alcoholics and alcohol abusers in Montana are not known at this time. The above mentioned indicators are only estimates based on available information.

The CSTAA grant (section 11) will enable Montana to acquire the statistical base for making more refined estimates of need. These will be compiled on a regional basis and utilized as part of the next state plan.

The lack of data base has been clearly described in the CSTAA proposal and the resulting shortcomings are evident. We believe that this problem of data and long range planning will be addressed with the material gathered through this evaluation instrument.

REGIONAL CONCEPT OF SERVICE DELIVERY

The regional utilization of formula funds has been administratively transferred from the Comprehensive Health Planning Regional Councils to the Regional Mental Health Boards. This transition was described in the fiscal year 75 State Plan. The regional mental health boards have only recently assumed this responsibility for alcoholism planning and the system is not yet operational. The regional plans for alcoholism prevention and treatment are being developed but are not ready for inclusion in this State Plan.

The regional mental health boards are tax exempt non-profit organizations that are separate and distinct from formal government structures; however, the members of the five (5) regional mental health boards are commissioners from the 56 counties of Montana. The regional mental health boards receive input from their members who are the county commissioners of the several counties served by the region. In addition, substantial citizen input is channelled to the regional mental health board through the advisory councils that are made up of residents of the several counties. This particular structure enables the mental health regional boards to solicit input both officially through the county commissioners and also through the citizen advisory councils. A listing of the mental health board members and the advisory council members is included later in this document.

Minority Representation

The significant minority residing in Montana is made up of native Americans residing on the seven (7) reservations and also native Americans residing in the urban areas of the State. The mental health regional boards will solicit input from both the native Americans residing on the reservations and those residing in the urban areas and this native American input will be incorporated into the regional plans submitted by the boards.

PROBLEM 1

Various portions of the problems related to alcoholism and alcohol abuse have been described in many ways. The following brief but impressive listing focuses on the total impact that is felt by every community in Montana. (Cit. ALCOHOLISM DIGEST, Vol. V, No. 4):

-There are more than 9 million alcoholics nationwide.

-Alcoholism, in some way, affects an estimated 45 million people.

-Nearly 500,000 teenagers are alcoholics.

-About 3 million women are addicted to alcohol.

-Five to 10 percent of the nation's workers are alcoholics, costing industry an estimated $10 billion annually.

-There are some 28,000 alcohol-related highway fatalities annually.

-Fifty percent of all homicides are alcohol-related.

-Fifty-five percent of all arrests are alcohol-related, with many involving violent crimes such as sexual assaults on women and children, stabbings, beatings and shootings.

-Forty percent of the patients in any given hospital are alcoholics.

-Seventy percent of the Army's enlisted men and 36 percent of the officers are either problem drinkers or heavy drinkers.

-Alcoholism is the number one problem among American Indians, affecting the group five times worse than non-Indians.

-Alcohol plays a major part in various deaths, injuries and accidents, including snowmobile accidents, burns, drownings, accidental poisonings, fire deaths, home and fatal aircraft accidents.

-Alcohol misuse has been implicated in the development of certain cancers.

-Alcohol abuse by pregnant, alcoholic mothers may negatively affect their offspring.

-The liver, heart, brain and other parts of the body may be adversely affected by alcohol abuse.

-And so on - - -

These statistics and impressions present the national impact related to alcoholism and alcohol abuse, however, Montana continues to be a "Heavy Drinking" state and ranks fourth highest in the nation in per capita consumption of alcoholic beverage. The impact is significant.

GOAL 1

This longest range goal will be the reduction of the impact on the people of Montana from alcoholism and alcohol abuse.

PROBLEM 1.1

A de-centralized plan that reflects a commitment to integrate programming into regional health and political systems. Responsibility for leadership for alcoholism programming will be vested in the local community. Local concerns' indigenous approaches for the control of alcoholism and involvement of community agencies will result in county programs which will differ from each other. Although the local programs will differ, the goals and objectives are uniformly defined in the Uniform Alcoholism and Intoxication Act. This decentralization and ultimate establishment of a wide range of services for each community

will be accomplished through a full utilization of the existing Mental Health Regional Boards.

Each Regional Mental Health Board will serve as the contract entity between the Department of Institutions, Addictive Diseases Bureau and the community with the Board itself operating a program directly or contracting it out to an alcoholism council, general hospital or some other local agency.

GOAL 1.1

This shorter range goal will be the establishment of a structure for implementation of a de-centralized regional concept of needs assessment and definition of a plan to meet the particular needs of each region.

Objective

1. June 14, 1976. To contract with Regional Mental Health Boards to utilize FY '75 formula funds by hiring a regional resource person for each of the five regions. The five regional staff persons will be hired by this date. Their titles will be "REGIONAL ADDICTIVE DISEASES RESOURCE DEVELOPMENT SPECIALISTS" (RADRDS).

Cost to Implement

$20,000 per region - funded from FY '75 formula funds.

Objective

2. June 25, 1976. To have provided two weeks of intensive training for the newly hired RADRDS. This training will be in the entire field of alcoholism and community organization.

The training will be staffed by Bureau of Addictive Diseases personnel and selected outside resource persons.

2.1 And to provide additional training on a monthly basis during the entire twelve months of the contract. The monthly training will be in three day blocks in the several regions. A portion of the training time will be used to evaluate the progress made in each region, and to assist in the development of regional needs assessments and regional alcohol plans for inclusion in the FY '77 State Alcohol Plan.

Cost to Implement

Each region will pay travel and per diem from FY '75 formula allocation. This will be a portion of the additional $20,000 of the FY '75 formula.

Objective

3. December 31, 1976. To have the RADRDS select and identify an alcoholism resource person in each county. The resource persons may be AA members, social service workers, police, clergy or any one in the community who could maintain a listing of available services and make referrals. The RADRDS will identify detox capabilities in the smaller communities and assist in the developing and refinement of the comprehensive range of alcoholism services in the larger communities.

No separate cost factor - included in regional allocation of FY '75 formula funds for salary and support services.

Objective

4. January 15, 1977. To have submitted the five regional alcoholism plans to the Department of Institutions for inclusion in the FY '77 Montana State Alcohol Plan. These regional plans should reflect the particular needs for alcoholism services existing in each of the five regions. Input into these regional plans will be solicited from the Regional Mental Health Boards, the Mental Health Advisory Councils, other service providers and from the community members at large.

Cost to Implement

Cost of paper, copying, etc, from the support budget for the RADRDS from FY '75 formula.

Objective

5. February 15, 1977. To have the State Alcohol Plan reviewed by the Alcohol and Drug Dependency Advisory Council.

Cost to Implement

Travel and per diem for the Council Members will come from State general fund monies.

Objective

6. March 1, 1977. To have the State Plan ready for public review and comment.

Cost to Implement

Bureau staff time - State general fund.

Objective

7. April 1, 1977. To have the State Plan for FY '77 approved by HEW, Region VIII staff.

PROBLEM 1.1

Same as Problem 1.

GOAL 1.1

Same as goal 1.

Objective

1. May 1, 1977. To provide continuation funding for the regional position that was contracted from 5-1-76 through 4-30-77. The continuation funding will carry the position through 9-30-77.

   June 1, 1977. To provide continuation funding for the four regional contracts for the period of 6-1-76 through 5-31-77. This continuation funding will carry these four positions through 9-30-77.

Cost to Implement

The cost to continue these five regional positions will be $2,083 per month for 21 months for a total of $43,750. These funds to come from FY '76 federal formula alcohol funds.

PROBLEM 2

The proportion of adult women who drink has been increasing steadily since World War II, and the results of recent surveys indicate that this

is continuing. About 47 percent of adult women now drink once a month or more.

There is a reported increase in the number of women exhibiting alcohol problems. Ten years ago, one out of every six persons with an alcohol problem was a woman, now it is one out of three. In a 1974 survey, Alcoholics Anonymous found that one out of every three new members in the last three years was a woman, and that women account for 28 percent of AA's total membership.

Dr. Morris Chafetz (1974) "However, in view of the recent significant increase in female problem drinkers concurrent with the women's liberation movement, it (heavy drinking) apparently may also result from a dissatisfaction or confusion about self-identity brought on by a new consciousness and pressure for change. Just as youth drink to achieve a demonstrable measure of adulthood, it may be that women who are confused about their current role are drinking heavily as a measure to indicate they have achieved status with men."

Attitudes of Society

Chafetz (1974) "Many women developing alcohol problems have the opportunity to do their drinking in isolation at home during the day, and they are able to progress a long way down the road to chronic alcoholism without the knowledge of either family or friends. Further, the woman who does become alcoholic is forced by society to carry a double burden. She is tagged with the moral stigma of alcoholism, and she is doubly

stigmatized because it has always been considered 'unladylike' for a woman to be drunk...As a result, family and friends continue to help conceal the woman's drinking problems. This delays recognition and treatment of her illness."

Alcoholism and alcohol abuse among Montana's women is a significant portion of the entire problem created by the use and misuse of alcoholic beverage in the State. The number of alcoholic women in Montana is not known, however, there is documentation that the problem is both very real and significant.

GOAL 2

This goal will be the establishment of services for the women of Montana who are alcoholics or abuse alcohol.

Objective

1. July 1, 1976. To fund three model programs that will provide alcoholism services to women. These will be located in Billings, Great Falls and Havre.

Cost to Implement

The cost for the implementation of this Objective will be included in the cost of Goal #4, Objective #1.

Objective

2. January 31, 1977. To evaluate the utilization and effectiveness of these three alcoholism service programs for women. The evaluation will be done with the process and methodology stated in the CSTAA evaluation grant.

Cost to Implement

The cost will be from the CSTAA grant.

Objective

3. February 28, 1977. To introduce all five RADRDS to these services for women. Visits will be arranged for the RADRDS to see and understand the services offered for women and to learn of the differing structures. The intent is that each of the five regions will be able to use the three programs for women as models for the development of similar services in all of the regions.

Cost to Implement

The cost will be travel and per diem for the RADRDS and will come from FY '75 formula allocation to each region.

PROBLEM 3 - YOUTHFUL ALCOHOL USE

Alcohol use and misuse among teenagers has recently been the target of much media attention and national concern. Numerous stories have appeared in hundreds of publications and television news shows throughout the country on teenage alcoholism, alcohol as the "drug of choice" of young people, students drinking while in school, and the impact of lowered legal drinking age on traffic accidents. This has resulted, on the one hand, in a panic similar to the drug scare of the early 1970's, and on the other, in genuine concern among people in contact with youth to discover what is happening and what should be done about it.

Trends in Adolescent Drinking Behavior

In an effort to discover the nature of drinking behavior among adolescents, a national survey was undertaken by the Center for the Study of Social Behavior for the National Institute on Alcohol Abuse and Alcoholism. The final report of April, 1975 states that about 74 percent of the adolescent population (national probability sample of all Junior and Senior High School students in grades 7-12 in the contiguous 48 states and the District of Columbia) have had a drink more than two or three times in their lives. Of the adolescents surveyed, one-half of whom are under 16 years of age, 54.8 percent drink once a month or more often and another 23.3 percent drink once a week or more often, with beer being the most frequently chosen beverage. On various scales to indicate problem drinking, the adolescents rank as follows:

-Almost 1 out of 4 (24.1 percent) report having been drunk 4 or more times during the previous year. This frequency for drunkenness is 3 or 4 times greater than for all drinkers.

-In reporting negative consequences of drinking, 17.1 percent of the youths mentioned difficulties with friends and 10.4 percent cited criticism from dates as a result of their drinking. Trouble with police was mentioned by 7 percent of the respondents and trouble with school personnel by 4.9 percent.

-40 percent of the students reported drinking in cars and 15.9 percent reported driving after having had a "good bit to drink".

-35 percent of the students said they drink alone at least sometimes.

-2.5 percent judged their drinking to be a "considerable" or "serious" problem while 9.8 percent stated they found their drinking to be a "mild" problem.

As in studies conducted at the local level, this national survey indicates that boys drink with greater frequency and in greater quantities than girls. However, there appears to be a noticeable shift toward more adolescent girls drinking alcoholic beverages than in previous samples.

As expected, the quantity and frequency of alcohol consumption increases with age. A dramatic shift between abstainer and drinker occurs from age 13-17.

White adolescents have the highest proportion of drinkers and Blacks the smallest proportion. American Indian youth have the highest proportion of heavy drinkers (as defined in this survey, heavy drinkers drink at least once a week and 5-12 drinks per occasion) (16.5 percent) followed by Orientals (13.5 percent), Spanish (10.9 percent), whites (10.7 percent) and Blacks (5.7 percent).

Drinking levels vary little by region of the country, and though some research indicates drinking levels vary inversely with urbanization levels, such differences did not show up significantly in the present study.

It should be noted that these data do not include high school dropouts, and studies indicate the dropout population has a higher proportion of drinkers than the in-school population. The levels of alcohol consumption by teenagers is probably underestimated because of this.

Statistics describing the consumption of alcoholic beverages by the youth of Montana are not available, however, it is reasonable to assume that the youth of this state make a substantial contribution to the state's rank as fourth highest in per capita consumption.

GOAL 3

This goal will be the establishment of alcoholism services specifically designed to serve the youth of the state who are alcoholics or who abuse alcoholic beverages.

Objective

1. July 1, 1976. To fund a model program to serve the youth who have problems associated with alcohol abuse. This specific program will be at Colstrip.

Cost to Implement

This cost to implement this objective will be included in the cost of Goal #4, Objective #1.

Objective

2. January 31, 1977. To evaluate the utilization and effectiveness of this specific program designed to serve the needs of youth with drinking problems. The evaluation will be done with the process and the methodology stated in the CSTAA evaluation grant.

Cost to Implement

The cost will be from the CSTAA grant.

Objective

3. February 28, 1977. To introduce all five RADRDS to this program serving youth. Visits will be arranged for the RADRDS

to see and understand the services offered for youth and to learn of the structure. The intent is that each of the five regions will be able to use this service as a model for the development of similar services in all of the regions.

Cost to Implement

The cost will be travel and per diem for the RADRDS and will come from FY '75 formula allocation to each region.

PROBLEM 4

Recent years have seen an increased understanding of the concept of a "range of services". By this is meant a variety of different services which are appropriate to patients at different stages of their recovery and for different patients. The emphasis is placed on modifying the present situation where we often are forced to send persons to one type of treatment setting because we don't have alternatives. This point can perhaps be illustrated by reference to the category of "intermediate care" or "transitional" facilities. As part of a comprehensive community alcoholism program, a variety of different intermediate care or transitional facilities are needed. These would range all the way from day-night hospital facilities, to halfway houses, three-quarterway houses, supervised boarding homes, sheltered workshops, and to daytime recreational facilities. Such different facilities emphasize varying degrees of independent living and make different demands on the patients in terms of ability to take their own initiative. The programs also would differ in kinds of rehabilitation being emphasized and in the

opportunities for socialization and resocialization. Merely talking in terms of a range of services -- inpatient care, outpatient care, partial hospitalization, emergency care, etc., -- represents a significant step forward as contrasted with exclusive focus on one element. However, we need to realize that particularly in the gray area between total institutional living and complete independent living in the community, there are many other alternatives that ought to exist. While this may appear to sound like an overwhelming and complex network, it should be thought of in terms of services or activities rather than in terms of facilities. There is no reason at all why one facility or physical structure could not provide a wide range of different services of the types described above.

This matter of the difference between a service and a facility is also highlighted by current discussions about "detoxification." All too often the emphasis is placed on detoxification in terms of a "center" rather than in terms of a particular service or even activity. It probably is much more realistic and appropriate to talk about "detoxification" as an activity which in any given community can and should be carried on in a variety of different settings. In any large metropolitan area we know that people are likely to appear at a variety of different settings when they need emergency care for excessive alcohol intake. A variety of different agencies in the community, located in different socioeconomic strata should be equipped and qualified to handle the medial-social emergencies associated with acute intoxication.

Thus, emergency medical care for acutely ill alcoholics should be present in all community facilities that handle other medical emergencies. In addition, and this will require considerable modifications in most American communities, these emergency medical facilities should also be equipped to deal with the emergency social problems that frequently are associated with medical emergencies. This will, of course, require the addition of certain specialized nonmedical personnel to these agencies.

Similarly, when we talk about diagnosis, referral, and screening, we can use these in terms of a physical facility or we can talk about these as a centralized service, or we can talk about the elements as activities which should be carried on with appropriately trained and oriented personnel in a variety of different settings. This is particularly important because problem drinkers often have been in contact with many different agencies. The objective, long range as well as short range, should be to equip the personnel of these various agencies so that they will be able to function appropriately in diagnostic, screening, and referral roles in relation to problem drinkers and their families. As important as the function of "referral" is, we need also to realize its limitations. In the past, referral has often been used by agencies to avoid working with those clients that they prefer to "dump" on to another agency. In addition, we know that in America generally, regardless of diagnosis, only a minority of patients referred from one agency to another actually end up receiving any treatment from the agency to which they have been referred. This "casualty rate" among referred cases is, of course, particularly high among problem drinkers and their families.

Not all Montana communities have a comprehensive range of services for the alcoholic or alcohol abuser and many of the Montana communities will not have this comprehensive range of services because of low population density and the expense of such services. The larger communities have or are developing this range of services. The smaller communities are seeking alternatives for the provision of these needed services for their residents.

GOAL 4

This goal will be the provision of a comprehensive range of alcoholism services for all Montana residents.

Objective

1. July 1, 1976. To provide supplementary funding for all of the existing alcoholism programs offering a comprehensive range of services for the residents of Montana. Montana does not have enough of these services and while there is considerable effort to develop new services, there is also a need to maintain and continue the existing programs that are currently serving the alcoholic and the alcohol abuser.

Cost to Implement

The cost to implement this objective has been arranged together with the cost to implement all of the objectives listed under goal 2, goal 3, and goal 4 and is as follows:

State general fund FY '77	$449,000	
State general fund FY '76	40,000	(estimated carryover)
Federal formula FY '76	156,250	
Title XX	123,000	
TOTAL	$768,250	

Objective

2. July 1, 1976. To provide supplementary funding for those new programs proposing to offer a comprehensive range of services for the alcoholic and the alcohol abuser.

Cost to Implement

Cost to implement has been included in the $768,250 figure listed under Objective 1.

The Montana needs for service to the alcoholic and the alcohol abuser are interwoven with the intent and philosophy of the recently passed Uniform Act. The Uniform Act clearly expresses these needs as felt by each Montana community. Essentially, when the Uniform Act has been fully implemented, the needs for service to the alcoholic and the alcohol abuser will be met.

The objectives stated in this section (1.6), i.e. the regionalization of service delivery, the resource persons (RADRDS), the service for women and youth are all efforts to implement the Uniform Act.

The incentive grant to assist with the implementation of the Uniform Act has been applied for and will be coordinated with the regional approach and the regional resource persons will have major responsibility for the utilization of the funds from the grant. All available local, state and federal funds will be used to fully implement the Uniform Act and thereby, provide the necessary services for the alcoholic and the alcohol abuser.

BUDGET BREAKDOWN

Federal formula FY 76	
Contracts for service with local community based alcoholism programs	$156,250
Costs to continue the five regional resource persons from expiration of FY 75 contracts through 9/30/77	43,750
	$200,000

None of the above mentioned FY 76 formula funds will be used for administration by the Single State Authority.

State general fund FY 76	
Contracts for service with local community based alcoholism programs	$449,000
Administration - Single State Authority	185,400
	$634,400

We developed a service philosophy for alcohol and drug programs alike. This philosophy, while not complex, will provide an opportunity to measure the qualitative effectiveness of our services - a long needed attribute. Our mission will be to increase the frequency of client participation in socially acceptable, productive activity as an alternative to dysfunctional abuse of alcohol or other addictive drugs. To measure accomplishment of this mission, we have outlined three measurable treatment objectives:

1. To reduce the number of drop-outs from our treatment programs.
2. To increase the frequency of contact between clients and program services.
3. And finally, to develop less client dependence on alcohol, drugs and our programs by increasing client participation in training/education, employment and community activities.

SECTION 2

2.1 LEGAL REFERENCES

2.2 POWERS AND DUTIES OF THE DEPARTMENT

2.3 MONTANA UNIFORM ACT

The passage of the Uniform Act by the Montana Legislature was a major advance in the recognition of alcoholism as an illness and constitutes a significant commitment by the state. The state legislation on alcoholism will need further upgrading and refinement as the regions of the state gain experience in the implementation of this act. The Single State Alcoholism Authority and the regional resource persons will be actively seeking to define the needs for future alcoholism legislation and will assist the Montana legislators in the development of new legislation as the needs are defined. A meeting of state staff and local alcohol program representatives is scheduled for August 26 and 27, 1976 to identify those legislative changes we will want considered by the legislature in January, 1977.

MONTANA STATE PLAN FY 76

LEGAL REFERENCES

REVISED CODES OF MONTANA
TITLE 80 - STATE INSTITUTIONS
CHAPTER 27 - ALCOHOL AND DRUG DEPENDENCE

80-2701. Purpose of intent of act -- policy of state.
80-2702. Duties of department--department authorized to accept--gifts--enter into contracts--acquire and dispose of property.
80-2703. Administration of federal program.
80-2704. Receipt of financial assistance authorized--cooperation with other agencies and organizations.
80-2705. Department to administer act.
80-2706. State and local government to cooperate with the department--not subject to its control.
80-2707. Deposit of funds from federal or private sources with state treasurer.
80-2708. Declaration of policy.
80-2709. Definitions.
80-2710. Powers of department.
80-2711. Duties of department.
80-2712. Comprehensive program for treatment.
80-2713. Facility standards--inspections--approvals.
80-2714. Acceptance for treatment--rules.
80-2715. Voluntary treatment of alcoholics.
80-2716. Treatment and services for intoxicated persons and persons incapacitated by alcohol.
80-2717. Emergency commitment.
80-2718. Involuntary commitment of alcoholics.
80-2719. Records of alcoholics and intoxicated persons.
80-2720. Visitation and communication of patients.
80-2721. Application of Administrative Procedure Act.
80-2722. Departmental reports to legislature.
80-2723. Criminal laws limitations.
80-2724. Public Intoxication not criminal offense.

FEDERAL STATUTES:

P.L. 91-616, Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970.
Title III, (84 STAT. 1849)
Sec. 303 (84 STAT. 1850)
Sec. 311 (84 STAT. 1851)

P.L. 93-282, Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act Amendments of 1974.
Sec. 111 (88 STAT. 129)

80-2710 and 80-2711, R.C.M. 1947, provide as follows:

"80-2710. Powers of department. The department may:

(1) plan, establish, and maintain treatment programs as necessary or desirable;

(2) coordinate its activities and cooperate with alcoholism programs in this and other states, and make contracts and other joint or cooperative arrangements with state, local, or private agencies in this and other states for the treatment of alcoholics and intoxicated persons and for the common advancement of alcoholism programs;

(3) do other acts and things necessary or convenient to execute the authority expressly granted to it; and

(4) provide treatment facilities for alcoholics and intoxicated persons."

"80-2711. Duties of department. The department shall:

(1) develop, encourage, and foster statewide, regional, and local plans and programs for the prevention of alcoholism and treatment of alcoholics and intoxicated persons in cooperation with public and private agencies, organizations, and individuals and provide technical assistance and consultation services for these purposes;

(2) coordinate the efforts and enlist the assistance of all public and private agencies, organizations, and individuals interested in prevention of alcoholism and treatment of alcoholics and intoxicated persons;

(3) cooperate with the department of institutions and board of

pardons in establishing and conducting programs to provide treatment for alcoholics and intoxicated persons in or on parole from penal institutions;

(4) cooperate with the department of education, the superintendent of public instruction, schools, police departments, courts, and other public and private agencies, organizations and individuals in establishing programs for the prevention of alcoholism and treatment of alcoholics and intoxicated persons, and preparing curriculum materials thereon for use at all levels of education;

(5) prepare, publish, evaluate, and disseminate educational material dealing with the nature and effects of alcohol;

(6) develop and implement, as an integral part of treatment programs, an educational program for use in the treatment of alcoholics and intoxicated persons, which program shall include the dissemination of information concerning the nature and effects of alcohol;

(7) organize and foster training programs for all persons engaged in treatment of alcoholics and intoxicated persons;

(8) sponsor and encourage research into the causes and nature of alcoholism and treatment of alcoholics and intoxicated persons, and serve as a clearing house for information relating to alcoholism;

(9) specify uniform methods for keeping statistical information by public and private agencies, organizations, and individuals, and collect and make available relevant statistical information, including number of persons treated, frequency of admission and readmission, and frequency and duration of treatment.

(10) advise the governor in the preparation of a comprehensive plan for treatment of alcoholics and intoxicated persons for inclusion in the state's comprehensive health plan;

(11) review all state health, welfare, and treatment plans to be submitted to federal funding under federal legislation, and advise the governor on provisions to be included relating to alcoholism and intoxicated persons;

(12) assist in the development of, and cooperate with, alcohol education and treatment programs for employees of state and local government and businesses and industries in the state;

(13) utilize the support and assistance of interested persons in the community, particularly recovered alcoholics, to encourage alcoholics voluntarily to undergo treatment;

(14) cooperate with the Department of Justice in establishing and conducting programs designed to deal with the problem of persons operating motor vehicles while intoxicated;

(15) encourage general hospitals and other appropriate health facilities to admit without discrimination alcoholics and intoxicated persons and to provide them with adequate and appropriate treatment;

(16) encourage all health and disability insurance programs to include alcoholism as a covered illness; and

(17) submit to the governor an annual report covering the activities of the DEPARTMENT."

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HOUSE BILL NO. 909

INTRODUCED BY FASBENDER, CAMPBELL, DRISCOLL, SWANBERG, MARKS MCKITTRICK, GREELY

AN ACT ADOPTING CERTAIN PROVISIONS OF THE UNIFORM ALCOHOLISM AND INTOXICATION ACT, INCREASING THE TAX ON ALCOHOLIC BEVERAGES TO CREATE A FUND FOR THE PROGRAMS AUTHORIZED BY THIS ACT, AMENDING SECTIONS 4-201, 4-240, 4-324, 11-927, AND 94-8-105, R.C.M. 1947, AND REPEALING SECTIONS 4-164 AND 69-6202, R.C.M. 1947.

This bill was received by the Governor this 16 day of March 1974

Governor

By

Approved 3-23-74

Governor

STATE OF MONTANA
DEPARTMENT OF SECRETARY OF STATE
FILED
March 25 1974
AT 3:00 P M
Frank Murray
SECRETARY OF STATE
BY
DEPUTY

March 8, 1974	Committee recommend that bill be concurred in. Report adopted. Bill referred to second reading.
	On motion placed on second reading for consideration this day.
	Committee of the Whole recommend that further action be indefinitely postponed. Report adopted.
	On motion segregated from report of Committee of the Whole.
	Passed consideration.
March 9, 1974	Committee of the Whole recommend bill be concurred in as amended. Report adopted. Referred to calendar for third reading.
	On motion rules suspended. Bill placed on calendar for third reading this day.
	Read third time and concurred in as amended. Title and history agreed to. Returned to House for concurrence in Senate amendments.

IN THE HOUSE

March 11, 1974	Referred to second reading for concurrence in Senate amendments.
March 12, 1974	Senate amendments concurred in by Committee of the Whole. Placed on calendar for third reading.
March 13, 1974	Senate amendments concurred in on third reading. Referred to Bills Committee for enrolling.
	Reported correctly enrolled.

HOUSE BILL NO. 909

INTRODUCED BY FASBENDER, CAMPBELL, DRISCOLL, SWANBERG, HANKS, MCKITTRICK, GREELY

IN THE HOUSE

SECOND REGULAR SESSION

January 17, 1974	Considered read and referred to Committee on Judiciary.
February 15, 1974	Committee recommends bill do pass as amended. Report adopted and referred to Bills Committee for printing.
February 19, 1974	Reported correctly printed. Report adopted. Referred to second reading.
February 20, 1974	Recommended favorably by Committee of the Whole as amended. Report adopted and referred to Bills Committee for engrossing.
February 21, 1974	Reported correctly engrossed. Report adopted and referred to calendar for third reading.
	On motion rules suspended and bill placed on third reading this day.
	Read three several times and passed. Title and history agreed to. Transmitted to the Senate for its concurrence.

IN THE SENATE

February 22, 1974	Considered read and referred to Committee on Taxation.
February 28, 1974	On motion taken from Committee on Taxation. Referred to Committee on Public Health, Welfare and Safety.

AN ACT ADOPTING CERTAIN PROVISIONS OF THE UNIFORM ALCOHOLISM AND INTOXICATION ACT, INCREASING THE TAX ON ALCOHOLIC BEVERAGES TO CREATE A FUND FOR THE PROGRAMS AUTHORIZED BY THIS ACT, AMENDING SECTIONS 4-201, 4-240, 4-324, 11-927, AND 94-8-105, R.C.M. 1947, AND REPEALING SECTIONS 4-164 AND 69-6202, R.C.M. 1947.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

Section 1. There is a new section to be numbered 69-6211, R.C.M. 1947, which reads as follows:

69-6211. Declaration of policy. It is the policy of the state of Montana to recognize alcoholism as an illness and that alcoholics and intoxicated persons may not be subjected to criminal prosecution because of their consumption of alcoholic beverages but rather should be afforded a continuum of treatment in order that they may lead normal lives as productive members of society.

Section 2. There is a new section to be numbered 69-6212, R.C.M. 1947, which reads as follows:

69-6212. Definitions. For purposes of this act:

(1) "alcoholic" means a person who habitually lacks self-control as to the use of alcoholic beverages, or uses alcoholic beverages to the extent that his health is substantially impaired or endangered or his social or economic function is substantially disrupted;

(2) "approved private treatment facility" means a private

agency meeting the standards prescribed in section 69-6216(1) and approved under section 69-6216;

(3) "approved public treatment facility" means a treatment agency operating under the direction and control of the department or providing treatment under this act through a contract with the department and approved under section 69-6216;

(4) "department" means the department of health and environmental sciences provided for in section 82A-601, R.C.M. 1947;

(5) "incapacitated by alcohol" means that a person, as a result of the use of alcohol, is unconscious or has his judgment otherwise so impaired that he is incapable of realizing and making a rational decision with respect to his need for treatment;

(6) "incompetent person" means a person who has been adjudged incompetent by the district court;

(7) "intoxicated person" means a person whose mental or physical functioning is substantially impaired as a result of the use of alcohol;

(8) "treatment" means the broad range of emergency, outpatient, intermediate, and inpatient services and care, including diagnostic evaluation, medical, psychiatric, psychological, and social service care, vocational rehabilitation and career counseling, which may be extended to alcoholics and intoxicated persons.

Section 3. There is a new section to be numbered 69-6213,

R.C.M. 1947, which reads as follows:

69-6213. Powers of department. The department may:

(1) plan, establish, and maintain treatment programs as necessary or desirable;

(2) coordinate its activities and cooperate with alcoholism programs in this and other states, and make contracts and other joint or cooperative arrangements with state, local, or private agencies in this and other states for the treatment of alcoholics and intoxicated persons and for the common advancement of alcoholism programs;

(3) do other acts and things necessary or convenient to execute the authority expressly granted to it; and

(4) provide treatment facilities for alcoholics and intoxicated persons.

Section 4. There is a new section to be numbered 69-6214, R.C.M. 1947, which reads as follows:

69-6214. Duties of department. The department shall:

(1) develop, encourage, and foster statewide, regional, and local plans and programs for the prevention of alcoholism and treatment of alcoholics and intoxicated persons in cooperation with public and private agencies, organizations, and individuals and provide technical assistance and consultation services for these purposes;

(2) coordinate the efforts and enlist the assistance of all public and private agencies, organizations, and individuals

interested in prevention of alcoholism and treatment of alcoholics and intoxicated persons;

(3) cooperate with the department of institutions and board of pardons in establishing and conducting programs to provide treatment for alcoholics and intoxicated persons in or on parole from penal institutions;

(4) cooperate with the department of education, the superintendent of public instruction, schools, police departments, courts, and other public and private agencies, organizations and individuals in establishing programs for the prevention of alcoholism and treatment of alcoholics and intoxicated persons, and preparing curriculum materials thereon for use at all levels of education;

(5) prepare, publish, evaluate, and disseminate educational material dealing with the nature and effects of alcohol;

(6) develop and implement, as an integral part of treatment programs, an educational program for use in the treatment of alcoholics and intoxicated persons, which program shall include the dissemination of information concerning the nature and effects of alcohol;

(7) organize and foster training programs for all persons engaged in treatment of alcoholics and intoxicated persons;

(8) sponsor and encourage research into the causes and nature of alcoholism and treatment of alcoholics and intoxicated persons, and serve as a clearing house for information relating to

alcoholism;

(9) specify uniform methods for keeping statistical information by public and private agencies, organizations, and individuals, and collect and make available relevant statistical information, including number of persons treated, frequency of admission and readmission, and frequency and duration of treatment;

(10) advise the governor in the preparation of a comprehensive plan for treatment of alcoholics and intoxicated persons for inclusion in the state's comprehensive health plan;

(11) review all state health, welfare, and treatment plans to be submitted for federal funding under federal legislation, and advise the governor on provisions to be included relating to alcoholism and intoxicated persons;

(12) assist in the development of, and cooperate with, alcohol education and treatment programs for employees of state and local governments and businesses and industries in the state;

(13) utilize the support and assistance of interested persons in the community, particularly recovered alcoholics, to encourage alcoholics voluntarily to undergo treatment;

(14) cooperate with the department of justice in establishing and conducting programs designed to deal with the problem of persons operating motor vehicles while intoxicated;

(15) encourage general hospitals and other appropriate health facilities to admit without discrimination alcoholics and

intoxicated persons and to provide them with adequate and appropriate treatment;

(16) encourage all health and disability insurance programs to include alcoholism as a covered illness; and

(17) submit to the governor an annual report covering the activities of the department.

Section 5. There is a new section to be numbered 69-6215, R.C.M. 1947, which reads as follows:

69-6215. Comprehensive program for treatment. (1) The department shall establish a comprehensive and coordinated program for the treatment of alcoholics and intoxicated persons.

(2) The program shall include:

(a) emergency treatment provided by a facility affiliated with or part of the medical service of a general hospital;

(b) inpatient treatment;

(c) intermediate treatment; and

(d) outpatient and followup treatment.

(3) The department shall provide for adequate and appropriate treatment for alcoholics and intoxicated persons admitted under sections 69-6218 to 69-6221. Treatment may not be provided at a correctional institution except for inmates.

(4) All appropriate public and private resources shall be coordinated with and utilized in the program if possible.

(5) The department shall prepare, publish, and distribute annually a list of all approved public and private treatment

facilities.

Section 6. There is a new section to be numbered 69-6216, R.C.M. 1947, which reads as follows:

69-6216. Facility standards -- inspections -- approvals. (1) The department shall establish standards for approved treatment facilities that must be met for a treatment facility to be approved as a public or private treatment facility, and fix the fees to be charged for the required inspections. The standards may concern only the health standards to be met and standards of treatment to be afforded patients.

(2) The department periodically shall inspect approved public and private treatment facilities at reasonable times and in a reasonable manner.

(3) The department shall maintain a list of approved public and private treatment facilities.

(4) Each approved public and private treatment facility shall file with the department on request, data, statistics, schedules, and information the department reasonably requires. An approved public or private treatment facility that without good cause fails to furnish any data, statistics, schedules, or information as requested, or files fraudulent returns thereof, shall be removed from the list of approved treatment facilities.

(5) The department, after holding a hearing in accordance with the Administrative Procedure Act, may suspend, revoke, limit, or restrict an approval, or refuse to grant an approval, for

failure to meet its standards.

(6) A district court may restrain any violation of this section, review any denial, restriction, or revocation of approval, and grant other relief required to enforce its provisions.

(7) Upon petition of the department and after a hearing held upon reasonable notice to the facility, a district court may issue a warrant to the department authorizing it to enter and inspect at reasonable times, and examine the books and accounts of, any approved public or private treatment facility refusing to consent to inspection or examination by the department or which the department has reasonable cause to believe is operating in violation of this act.

Section 7. There is a new section to be numbered 62-6217, R.C.M. 1947, which reads as follows:

62-6217. Acceptance for treatment; rules. The department shall adopt rules for acceptance of persons into the treatment program, considering available treatment resources and facilities, for the purpose of early and effective treatment of alcoholics and intoxicated persons. In adopting the rules the department shall be guided by the following standards:

(1) If possible a patient shall be treated on a voluntary rather than an involuntary basis.

(2) A patient shall be initially assigned or transferred to outpatient or intermediate treatment, unless he is found to

require inpatient treatment.

(3) A person shall not be denied treatment solely because he has withdrawn from treatment against medical advice on a prior occasion or because he has relapsed after earlier treatment.

(4) An individualized treatment plan shall be prepared and maintained on a current basis for each patient.

(5) Provision shall be made for a continuum of coordinated treatment services, so that a person who leaves a facility or a form of treatment will have available and utilize other appropriate treatment.

Section 8. There is a new section to be numbered 62-6218, R.C.M. 1947, which reads as follows:

62-6218. Voluntary treatment of alcoholics. (1) An alcoholic may apply for voluntary treatment directly to an approved public treatment facility. If the proposed patient is a minor or an incompetent person, he, a parent, a legal guardian, or other legal representative may make the application.

(2) Subject to rules adopted by the department, the administrator of an approved public treatment facility may determine who shall be admitted for treatment. If a person is refused admission to an approved public treatment facility, the administrator, subject to departmental rules, shall refer the person to another approved public treatment facility for treatment if possible and appropriate.

(3) If a patient receiving inpatient care leaves an approved

public treatment facility, he shall be encouraged to consent to appropriate out-patient or intermediate treatment. If it appears to the administrator of the treatment facility that the patient is an alconolic who requires help, the department shall arrange for assistance in obtaining supportive services and residential facilities.

(4) If a patient leaves an approved public treatment facility, with or against the advice of the administrator of the facility, the department shall make reasonable provisions for his transportation to another facility or to his home. If he has no home he shall be assisted in obtaining shelter. If he is a minor or an incompetent person the request for discharge from an inpatient facility shall be made by a parent, legal guardian, or other legal representative or by the minor or incompetent if he was the original applicant.

Section 9. There is a new section to be numbered 62-6219, R.C.M. 1947, which reads as follows:

62-6219. Treatment and services for intoxicated persons and persons incapacitated by alcohol. (1) An intoxicated person may come voluntarily to an approved public treatment facility for emergency treatment. A person who appears to be intoxicated in a public place and to be in need of help, if he consents to the proffered help, may be assisted to his home, an approved public treatment facility, an approved private treatment facility, or other health facility by the police.

(2) A person who appears to be incapacitated by alcohol shall be taken into protective custody by the police and forthwith brought to an approved public treatment facility for emergency treatment. If no approved public treatment facility is readily available he shall be taken to an emergency medical service customarily used for incapacitated persons. The police, in detaining the person and in taking him to an approved public treatment facility, is taking him into protective custody and shall make every reasonable effort to protect his health and safety. In taking the person into protective custody, the detaining officer may take reasonable steps to protect himself. No entry or other record may be made to indicate that the person taken into custody under this section has been arrested or charged with a crime.

(3) A person who comes voluntarily or is brought to an approved public treatment facility shall be examined by a licensed physician as soon as possible. He may then be admitted as a patient or referred to another health facility. The referring approved public treatment facility shall arrange for his transportation.

(4) A person who by medical examination is found to be incapacitated by alcohol at the time of his admission or to have become incapacitated at any time after his admission, may not be detained at the facility (1) once he is no longer incapacitated by alcohol, or (2) if he remains incapacitated by alcohol for more

than forty-eight (48) hours after admission as a patient, unless he is committed under section 69-6220. A person may consent to remain in the facility as long as the physician in charge believes appropriate.

(5) A person who is not admitted to an approved public treatment facility and is not referred to another health facility, may be taken to his home. If he has no home, the approved public treatment facility shall assist him in obtaining shelter.

(6) If a patient is admitted to an approved public treatment facility, his family or next of kin shall be notified as promptly as possible. If an adult patient who is not incapacitated requests that there be no notification, his request shall be respected.

Section 10. There is a new section to be numbered 69-6220, R.C.M. 1947, which reads as follows:

69-6220. Emergency commitment. (1) An intoxicated person who (a) has threatened, attempted, or inflicted physical harm on another and is likely to inflict physical harm on another unless committed, or (b) is incapacitated by alcohol, may be committed to an approved public treatment facility for emergency treatment. A refusal to undergo treatment does not constitute evidence of lack of judgment as to the need for treatment.

(2) The certifying physician, spouse, guardian, or relative of the person to be committed, or any other responsible person, may make a written application for commitment under this section,

directed to the administrator of the approved public treatment facility. The application shall state facts to support the need for emergency treatment and be accompanied by a physician's certificate stating that he has examined the person sought to be committed within two (2) days before the certificate's date and facts supporting the need for emergency treatment. A physician employed by the admitting facility or the department is not eligible to be the certifying physician.

(3) Upon approval of the application by the administrator of the approved public treatment facility, the person shall be brought to the facility by a peace officer, health officer, the applicant for commitment, the patient's spouse, the patient's guardian, or any other interested person. The person shall be retained at the facility to which he was admitted, or transferred to another appropriate public or private treatment facility, until discharged under subsection (5).

(4) The administrator of an approved public treatment facility shall refuse an application if in his opinion the application and certificate fail to sustain the grounds for commitment.

(5) When on the advice of the medical staff the administrator determines that the grounds for commitment no longer exist, he shall discharge a person committed under this section. No person committed under this section may be detained in any treatment facility for more than five (5) days. If a petition for

involuntary commitment under section 69-6221 has been filed within the five (5) days and the administrator in charge of an approved public treatment facility finds that grounds for emergency commitment still exist, he may detain the person until the petition has been heard and determined, but no longer than ten (10) days after filing the petition.

(6) A copy of the written application for commitment and of the physician's certificate, and a written explanation of the person's right to counsel, shall be given to the person within twenty-four (24) hours after commitment by the department, who shall provide a reasonable opportunity for the person to consult counsel.

Section 11. There is a new section to be numbered 69-6221, R.C.M. 1947, which reads as follows:

69-6221. Involuntary commitment of alcoholics. (1) A person may be committed to the custody of the department of institutions by the district court upon the petition of his spouse or guardian, a relative, the certifying physician, or the chief of any approved public treatment facility. The petition shall allege that the person is an alcoholic who habitually lacks self-control as to the use of alcoholic beverages and that he (a) has threatened, attempted, or inflicted physical harm on another and that unless committed is likely to inflict physical harm on another; or (b) is incapacitated by alcohol. A refusal to undergo treatment does not constitute evidence of lack of judgment as to

the need for treatment. The petition shall be accompanied by a certificate of a licensed physician who has examined the person within two (2) days before submission of the petition, unless the person whose commitment is sought has refused to submit to a medical examination, in which case the fact of refusal shall be alleged in the petition. The certificate shall set forth the physician's findings in support of the allegations of the petition. A physician employed by the admitting facility or the department is not eligible to be the certifying physician.

(2) Upon filing the petition, the court shall fix a date for a hearing no later than ten (10) days after the date the petition was filed. A copy of the petition and of the notice of the hearing, including the date fixed by the court, shall be served on the petitioner, the person whose commitment is sought, his next of kin other than the petitioner, a parent or his legal guardian if he is a minor, the administrator in charge of the approved public treatment facility to which he has been committed for emergency care, and any other person the court believes advisable. A copy of the petition and certificate shall be delivered to each person notified.

(3) At the hearing the court shall hear all relevant testimony, including, if possible, the testimony of at least one licensed physician who has examined the person whose commitment is sought. The person shall have a right to have a licensed physician of his own choosing examine him and testify on his

behalf, and if he has no funds with which to pay such physician, the reasonable costs of one such examination and testimony shall be paid by the county. The person shall be present unless the court believes that his presence is likely to be injurious to him; he shall be advised of his right to counsel and, if he is unable to hire his own counsel, the court shall appoint an attorney to represent him at the expense of the county. The court shall examine the person in open court, or if advisable, shall examine the person in chambers. If he refuses an examination by a licensed physician and there is sufficient evidence to believe that the allegations of the petition are true, or if the court believes that more medical evidence is necessary, the court may make a temporary order committing him to the department of institutions for a period of not more than five (5) days for purposes of a diagnostic examination.

(4) If after hearing all relevant evidence, including the results of any diagnostic examination by the department of institutions, the court finds that grounds for involuntary commitment have been established by clear and convincing evidence, it shall make an order of commitment to the department of institutions. It may not order commitment of a person unless it determines that the department of institutions is able to provide adequate and appropriate treatment for him and the treatment is likely to be beneficial.

(5) A person committed under this section shall remain in

the custody of the department of institutions for treatment for a period of thirty (30) days unless sooner discharged. At the end of the thirty (30) day period, he shall be discharged automatically unless the department of institutions before expiration of the period obtains a court order from the district court of the committing district for his recommitment upon the grounds set forth in subsection (1) for a further period of ninety (90) days unless sooner discharged. If a person has been committed because he is an alcoholic likely to inflict physical harm on anotner, the department of institutions shall apply for recommitment if after examination it is determined that the likelihood still exists.

(6) A person recommitted under subsection (5) who has not been discharged by the department of institutions before the end of the ninety (90) day period shall be discharged at the expiration of that period unless the department of institutions, before expiration of the period, obtains a court order from the district court of the committing district on the grounds set forth in subsection (1) for recommitment for a further period not to exceed ninety (90) days. If a person has been committed because he is an alcoholic likely to inflict physical harm on another, the department shall apply for recommitment if after examination it is determined that the likelihood still exists. Only two (2) recommitment orders under subsections (5) and (6) are permitted.

(7) Upon the filing of a petition for recommitment under

subsections (5) or (6), the court shall fix a date for hearing no later than ten (10) days after the date the petition was filed. A copy of the petition and of the notice of hearing, including the date fixed by the court, shall be served on the petitioner, the person whose commitment is sought, his next of kin other than the petitioner, the original petitioner under subsection (1) if different from the petitioner for recommitment, one of his parents or his legal guardian if he is a minor, and any other person the court believes advisable. At the hearing the court shall proceed as provided in subsection (3).

(8) A person committed to the custody of the department of institutions for treatment shall be discharged at any time before the end of the period for which he has been committed if either of the following conditions is met:

(a) in case of an alcoholic committed on the grounds of likelihood of infliction of physical harm upon another, that he is no longer in need of treatment or the likelihood no longer exists; or

(b) in case of an alcoholic committed on the grounds of the need of treatment and incapacity, that the incapacity no longer exists, further treatment will not be likely to bring about significant improvement in the person's condition, or treatment is no longer adequate or appropriate.

(9) The court shall inform the person whose commitment or recommitment is sought of his right to contest the application, be

represented by counsel at every stage of any proceedings relating to his commitment and recommitment, and have counsel appointed by the court or provided by the court, if he wants the assistance of counsel and is unable to obtain counsel. If the court believes that the person needs the assistance of counsel, the court shall require, by appointment if necessary, counsel for him regardless of his wishes. The person whose commitment or recommitment is sought shall be informed of his right to be examined by a licensed physician of his choice. If the person is unable to obtain a licensed physician and requests examination by a physician, the court shall employ a licensed physician.

(10) If a private treatment facility agrees with the request of a competent patient or his parent, spouse, adult child, or guardian to accept the patient for treatment, the department of institutions may transfer him to the private treatment facility.

(11) A person committed under this section may at any time seek to be discharged from commitment by writ of habeas corpus or other appropriate means.

(12) The venue for proceedings under this section is the place in which person to be committed resides or is present.

Section 12. There is a new section to be numbered 69-6222, R.C.M. 1947, which reads as follows:

69-6222. Records of alcoholics and intoxicated persons. (1) The registration and other records of treatment facilities shall remain confidential and are privileged to the patient.

(2) Notwithstanding subsection (1), the department may make available information from patients' records for purposes of research into the causes and treatment of alcoholism. Information under this subsection shall not be published in a way that discloses patients' names or other identifying information.

Section 13. There is a new section to be numbered 69-6223, R.C.M. 1947, which reads as follows:

69-6223. Visitation and communication of patients. (1) Subject to reasonable rules regarding hours of visitation which the department may adopt, patients in any approved treatment facility shall be granted opportunities for adequate consultation with counsel, and for continuing contact with family and friends consistent with an effective treatment program.

(2) Neither mail nor other communication to or from a patient in any approved treatment facility may be intercepted, read, or censored. The administrator may adopt reasonable rules regarding the use of telephone by patients in approved treatment facilities.

Section 14. There is a new section to be numbered 69-6224, R.C.M. 1947, which reads as follows:

69-6224. Application of Administrative Procedure Act. The Administrative Procedure Act applies to and governs all administrative actions taken under this act.

Section 15. Section 4-201, R.C.M. 1947, is amended to read as follows:

"4-201. Interdiction -- order of -- effect. (1) Where it appears to the satisfaction of a district court that an individual lacks self-control as to the use of alcoholic beverages, or uses alcoholic beverages to the extent that his health is substantially impaired or endangered or his social or economic function is substantially disrupted, the court may make an order of interdiction prohibiting the sale of liquor to him until further order; and the court shall cause the order to be forthwith filed with the department of revenue.

(2) On the making of an order for interdiction the interdicted person may forthwith deliver to the department all liquor then in his possession or under his control to be kept for him by the board until the order of interdiction is revoked or set aside, or to be purchased by the department at a price to be fixed by it. All liquor not delivered to the department under this subsection may be confiscated and forfeited to the state."

Section 16. Section 11-927, R.C.M. 1947, is amended to read as follows:

"11-927. Prevention of and punishment for disturbing the peace. The city or town council has power: To prevent and punish intoxication (subject to the limits established in section 69-6224), fights, riots, loud noises, disorderly conduct, obscenity, and acts or conduct calculated to disturb the public peace, or which are offensive to public morals, within the city or town, and within three miles of the limits thereof."

Section 17. Section 4-240, R.C.M. 1947, is amended to read as follows:

"4-240. License tax on liquor -- amount -- distribution of proceeds. The department of revenue is hereby authorized and directed to charge, receive and collect at the time of sale and delivery of any liquor under any provisions of the laws of the state of Montana a license tax of five percent (5%) of the retail selling price on all liquor so sold and delivered. Said tax shall be charged and collected on all liquor brought into the state and taxed by the department of revenue. The retail selling price shall be computed by adding to the cost of said liquor the state markup as designated by said board. Said five percent (5%) license tax shall be figured in the same manner as the state excise tax and shall be in addition to said state excise tax. The department of revenue shall retain the amount of such five percent (5%) license tax so received in a separate account. Four-fifths (4/5) of these revenues shall be distributed to the counties according to the amount of liquor purchased in each county. One-fifth (1/5) of these revenues shall be deposited in the general fund. Provided, however, in the case of purchases of liquor by a retail liquor licensee for use in his business, the department shall make such regulations as are necessary to apportion that proportion of license tax so generated to the county where the licensed establishment is located, for use as provided in section 4-241, R.C.M. 1947. The department of

revenue shall pay quarterly to each county treasurer the proportion of the license tax due each county.

The county treasurer of each county shall retain one-fourth (1/4) of said license tax, and shall, within thirty (30) days after receipt thereof, apportion the remaining three-fourths (3/4) thereof to the treasurers of the incorporated cities and towns within his county, said apportionment to be based in each instance upon the proportion which the gross sale of liquor in such incorporated city or town bears to the gross sale of liquor in all of the incorporated cities and towns in his said county."

Section 18. Section 4-324, R.C.M. 1947, is amended to read as follows:

"4-324. Tax on imported beer -- computation in case of barrels of capacity other than thirty-one gallons. A tax of three dollars ($3) per barrel of thirty-one (31) gallons, is hereby levied and imposed on each and every barrel of beer manufactured out of this state and sold herein by any wholesaler, which said tax shall be due at the end of each month from said wholesaler, upon any such beer so sold by him during that month. As to any beer imported and sold in containers other than barrels, or in barrels of more or less capacity than thirty-one (31) gallons, the quantity content shall be ascertained and computed by the department of revenue in determining the amount of tax due, as herein provided for. An additional tax of twenty-five cents ($.25) per barrel is levied and imposed as provided by this

section, and such additional tax is also to be levied and imposed at the same rate upon beer manufactured within the state. The additional tax of twenty-five cents ($.25) is to be deposited, notwithstanding sections 4-347, 4-347.1, or any other provision, in the general fund."

Section 19. There is a new section to be numbered 69-6224, R.C.M. 1947, which reads as follows:

69-6224. Departmental reports to legislature. The department and the department of institutions shall achieve full implementation of the provisions of the act, as set forth in this chapter and related sections, no later than January 1, 1976. A progress report on the implementation shall be made to the 1975 legislative session. Thereafter the departments shall report, to each legislative session, on the status of the implemented act. This report, or any part thereof, may be included as the department's state plan for alcohol abuse and alcoholism.

Section 20. Sections 4-164 and 69-6202, R.C.M. 1947, are repealed.

I hereby certify that the within bill originated in the House.

Chief Clerk

Speaker of the House
Signed this 16th day
of March, 1974.

President of the Senate
Signed this 16th day
of MARCH, 1974.

SECTION 3

3.1 ASSURANCES

3.2 LETTER OF ACCEPTANCE FROM THE ADVISORY COUNCIL

3.3 A-95 REVIEW AND COMMENT

3.4 PROOF OF AVAILABILITY FOR PUBLIC REVIEW (30 days)

MONTANA STATE PLAN FY 76

ASSURANCES

MAINTENANCE OF EFFORT. The State of Montana hereby provides assurance that Federal funds will not supplant non-Federal funds that may be otherwise available for provision of the services and carrying out the activities under this Plan. Such funds will, to the extent practical, be used to increase the level of funds otherwise available for such services and activities.

MERIT SYSTEM. The Addictive Diseases Bureau of the Montana Department of Institutions is a participating agency in the Montana State Merit System Plan. This Plan is developed and administered in accordance with "Standards for a Personnel Merit System", 45 EPR, Part 70.

NONDISCRIMINATION. All services provided under this State Plan will be made available without discrimination on account of race, creed, color, sex, marital status, or duration of residence.

The Department of Institutions and any other agency, organization, or institution carrying out any authority under the State Plan shall not discriminate in any way against any employee with respect to compensation, terms, conditions, or privileges of employment solely because of race, color, creed, sex, or national origin, nor shall they refuse employment to any qualified applicant for a position solely on the basis of the fact that he or she had or has not had a problem of alcohol abuse or alcoholism.

No formula grant funds will be awarded to public or private general hospitals which have received Federal funds for alcoholic

treatment programs and which refuse admission and treatment to alcoholic persons solely on the basis of their alcoholism.

NO CONFLICT OF INTEREST. No employee of the Department of Institutions nor any firm, organization, or corporation receives funds from any applicant directly or indirectly in payment for services provided in connection with the Montana State Plan for Alcohol Abuse and Alcoholism. Applicant agencies requesting subgrant funds will be required to submit a similar assurance.

Submission of the Plan will be by registered mail to the Regional Health Director, Regional Office, Department of Health, Education and Welfare, Denver, Colorado in such numbers of copies as they may require.

ACCOUNTING PROCEDURES. Accounting procedures necessary to assure proper disbursement of and accounting for funds paid to the State under this formula grant program have been established by the Management Services Division of the Department. Funds allocated to Montana in the Alcohol formula grant program under Public Law 91-616 will be clearly delineated from those obtained under other Federal formula or project grant programs. To this point, the budget number for this program has been established as 1001, Alcoholism Grant Program, for fiscal control purposes.

All records will be kept for such periods of time as deemed necessary for completion of Federal Audit as specified in the Guidelines for the Formula Grant Program under Public Law 91-616 and amendments.

Fiscal records relative to the use of funds made available under Public Law 91-616 and amendments shall be made available to

inspection and fiscal audit at reasonable times by persons designated by the Secretary.

REPORTS. Annual progress and expenditure reports shall be submitted as may be required, to the Associate Regional Health Director, Department of Health, Education, and Welfare, Region VIII, Denver, with a copy to the Director of the National Institute on Alcohol Abuse and Alcoholism.

ACCESSIBILITY. All the services provided under this plan will be so publicized as to be generally known to the population to be served, and will be available and responsive to the needs of those to be served, and will be so located as to be readily accessible to the population to be served.

SUBMISSION, REVIEW, AND APPROVAL OF THE STATE PLAN. The State Plan will be reviewed and updated or revised as necessary, at least annually. The Plan will be modified during the year if such modification is deemed necessary, and also as new or revised data or information is available, any revisions or updating will be subject to the same review procedure as the plan itself.

In years subsequent to this submission, the procedure to be followed in the submission and review of the plan will be as follows;

As soon as possible following submission of the plan for a fiscal year, staff revision and updating of the document will begin. The plan for fiscal year 1977 will be developed and prepared for review by the Advisory Council as early in the fiscal year as is practical.

Following Council review and comments, the documents will be made available for public review and comment at the Executive Office of the Department of Institutions, 1539 11th Avenue, Helena, Montana, as well as the office of the Addictive Diseases Bureau of the Department. Such availability will be announced through a description of the plan and a notice of its availability, which will be published 30 days prior to submission for approval.

Following this 30 day review period, copies will be submitted to the Office of the Governor to the A-95 Clearinghouse for their review and comments relative to the relationship of this plan or any modifications of the plan to comprehensive and other State plans and programs and will provide the Department of Health, Education, and Welfare with their comments.

Forty-five days will be allocated for such review, and any comments or statements that there are no comments will be submitted with the plan.

Nondiscrimination

That all services provided under the State Plan will be made available without discrimination on account of sex, duration of residence or ability or inability to pay for such services. In addition, Title VI of the Civil Rights Act of 1964 (42 USC 2000d; 78 Stat. 252), which provides that no person in the United States shall, on the ground of race, color, creed, or national origin be excluded from participation in, be denied the benefits of, or be

subjected to discrimination under any program or activity receiving Federal financial assistance, is applicable to services and programs provided under the State Plan.

2. That no formula grant funds will be awarded to public or private general hospitals which have received Federal funds for alcoholic treatment programs and which refuse admission and treatment to alcoholic persons solely on the basis of their alcoholism.

All of the other required assurances as described in previous State Plans are being met by this FY 76 Plan.

State of Montana

Department of Institutions

GOVERNOR
THOMAS L. JUDGE

DIRECTOR
ROBERT H. MATTSON

BOARD MEMBERS
ZELLA A. JACOBSON, GREAT FALLS
ELDON E. KUHNS, BILLINGS
WILLIS M. McKEON, MALTA
ROBERT J. PALLO, KALISPELL
JOHN W. STRIZICH, M.D., HELENA

Helena, 59601

RECEIVED
MAY 25 1976
DEPARTMENT OF INSTITUTIONS

May 25, 1976

Dr. Robert H. Mattson
Director
Department of Institutions
1539 11th Ave.
Helena, Montana 59601

Dear Dr. Mattson:

The FY'76 Montana State Alcohol Plan has been developed to assist in the planning, establishing, maintaining, coordinating and evaluating projects for alcohol abuse and alcoholism.

The need for continuing effort in planning and program development to lessen the impact of alcoholism on the residents of Montana remains a high priority. The Department of Institutions and the Bureau of Addictive Diseases should be applauded for their activities designed to establish, maintain and improve the services for the alcoholic and the alcohol abuser.

The details of this Plan have been reviewed by the Montana Alcohol and Drug Advisory Council and the Council concurs with the proposed activities and utilization of the formula funds that will be made available to Montana.

Sincerely yours,

Robert L. VanHorne, Ph.D.
Chairman
Advisory Council

cc: Dr. Larry Carlson, Administrator
Adaptive Services Division

Michael A. Murray, Chief
Addictive Diseases Bureau

AVAILABILITY OF STATE ALCOHOL PLAN FOR FY 76

EAT FALLS TRIBUNE

PUBLIC NOTICE

The 1976 Montana State Plan for Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation, compiled by the Montana Department of Institutions will be available for public review and comment for thirty days following the publication of this notice. Copies of this plan may be reviewed at the Administrative Office of the Montana Department of Institutions, 1539 Eleventh Avenue, Helena, Montana, phone: 449-3970. Individual copies of the plan are available upon request.

This Montana State Plan for Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation is for Fiscal Year 1976 and has been developed in accord with guidelines for the development of such plans as required by the National Institute on Alcohol Abuse and Alcoholism. The monies being sought through the development of this state plan are formula grant funds authorized to assist the states in the planning, establishing, maintaining, coordinating and evaluating projects for alcohol abuse and alcoholism. This authorization is contained in the "Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation and Alcoholism Prevention, Treatment, and Rehabilitation Act Amendments of 1974," Public Law 93-282.

Copies of this plan will be submitted to the Regional Office of the Department of Health, Education and Welfare in Denver, Colorado for review and approval. Copies have also been submitted to appropriate state and local agencies for their review and comment.

Interested persons concerned with alcohol abuse and alcoholism programming are encouraged to review and comment upon the plan. Those wishing to comment in writing are asked to do so, address their comments to the Bureau of Addictive Diseases, Montana Department of Institutions, 1539 Eleventh Avenue, Helena, Montana 59601.

BILLINGS GAZETTE

PUBLIC NOTICE

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Date of Publication: 5/23/76

INDEPENDENT RECORD HELENA

LEGALS

PUBLIC NOTICE
State of Montana
Department of Institutions
Helena, Mont.

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May 23, 1976

MISSOULIAN

Legal Publications

PUBLIC NOTICE

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May 23, 1976

MONTANA STANDARD BUTTE

Legal Notices

PUBLIC NOTICE

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5 23

SECTION 4

4.1 ADVISORY COUNCIL MEMBERS

4.2 ADVISORY COUNCIL BY LAWS

4.3 ADVISORY COUNCIL AGENDAS AND MINUTES OF MEETINGS

MONTANA ADVISORY COUNCIL on ALCOHOL and DRUG DEPENDENCY

LARRY FASBENDER
Farmer, Legislator
Assistant Majority Floor Leader - Montana Senate
Home Address: Route 1, Box 23
Home Phone: 624-2425
Fort Shaw, Montana 59443

KATHERINE A. HANRAHAN
Assistant Librarian, Dawson College
Office Phone: 365-3396
Home Address: 710 N. Meade Avenue
Home Phone: 365-2674
Glendive Montana 59330

GERALD B. HALL
Lieutenant, Great Falls Police Department
Office Phone: 727-6500
Home Address: Route 1 West, Box 236C
Home Phone: 452-1791
Great Falls, Montana 59401
Consultant to College of Great Falls on Drug Education Law Enforcement Drug Specialist

MARTHA S. HERLEVI
Legislator, House of Representatives District #71
Home Address: 221-East 11th
Home Phone: 446-2871
Red Lodge, Montana 59068

CARL KIPP, SR.
Secretary, Blackfeet Tribal Council
Office Phone: 338-5311
Browning, Montana 59417
Member of Blackfeet Tribe

SHARON PETTIT
Registered Nurse
Home Address: 715 Power
Home Phone: 442-9841
Office Phone: 443-4020
Helena, Montana 59601

PEGGY SKELTON
Elementary Teacher
Home Address: 2514 South Hills Drive
Home Phone: 549-3147
Missoula, Montana 59801
Member of Crow Tribe

ROBERT L. VAN HORNE, Ph.D.
School of Pharmacy
University of Montana
Office Phone: 243-4111
Home Address: 4 Martha's Court
Home Phone: 549-2152
Missoula, Montana 59801

The Advisory Council membership has been established so that both minority and poverty interests are represented.

STATE OF MONTANA

OFFICE OF THE

SECRETARY OF STATE

FRANK MURRAY
SECRETARY OF STATE

CARL M. DAVIS
CHIEF DEPUTY

HELENA, MONTANA 59601

September 22, 1975

Dr. Robert H. Mattson
Director of Institutions
Capitol Station
Helena, Montana 59601

Dear Dr. Mattson:

On September 12, 1975, Governor Judge approved the transfer and amendment of the ALCOHOL AND DRUG DEPENDENCY ADVISORY COUNCIL and filed record of such in this office. A copy of such record upon which I have placed my filing endorsement is enclosed for your files.

Please be advised that each person listed in the record has filed the necessary Oath of Office, with the exception of Mr. Kip. An oath of office form has been forwarded to him as a new member of the Council.

Sincerely yours,

FRANK MURRAY
Secretary of State

FM/cm
Encl.

cc: The Honorable Thomas L. Judge
Governor of Montana

John S. Anderson, M. D.
Director of Health & Environmental Sciences

Secretary of State

By _____ Deputy

STATE OF MONTANA

RECORD OF TRANSFER AND AMENDMENT AND GOVERNOR'S APPROVAL OF THE ALCOHOL AND DRUG DEPENDENCY ADVISORY COUNCIL.

THE ALCOHOL AND DRUG DEPENDENCY ADVISORY COUNCIL IS HEREBY TRANSFERRED FROM THE DEPARTMENT OF HEALTH AND ENVIRONMENTAL SCIENCES TO DEPARTMENT OF INSTITUTIONS IN ACCORDANCE WITH CHAPTER 280, SESSION LAWS OF 1975.

Composition is amended as follows: The Council shall be composed of 9 members.

NEW MEMBER:	ADDRESS:
Carl Kip	Browning

The following members shall continue to serve:

Shari Pettit	Helena
Peggy Skelton	Missoula
Robert L. Van Horne	Missoula
Larry Fasbender	Fort Shaw
Katherine A. Kamphan	Glendive
Gerald B. Hall	Great Falls
Martha S. Merlevi	Red Lodge

The following members are no longer serving:

Larry J. Schroeder	Billings
Mona L. Sumner	Billings
Gail Tyler	Missoula (Moore)
William L. McClaren	Kalispell
Dorothy Adamson	Browning
John K. Allen	Helena

Percy DeWolfe	Browning
Paul J. Everett, Jr.	Anaconda
W. Richard Ives	Havre
Allen LeMieux	Boulder
Simon Looking Elk	

Robert H. Mattson, Director
Department of Institutions

APPROVED:

12th day of Dec.

THOMAS L. JUDGE, Governor

ATTEST:

Secretary of State

MONTANA STATE PLAN FY 76

BY-LAWS OF THE

MONTANA ADVISORY COUNCIL ON ALCOHOL AND DRUG DEPENDENCY

ARTICLE I

NAME

The name of the Council is the Montana Advisory Council on Alcohol and Drug Dependency.

ARTICLE II

PURPOSE

The purpose of the Council shall be to comply with Public Laws which require an advisory council for receipt of State and Federal alcohol and drug grant monies. The Council will advise the Department of Institutions.

ARTICLE III

MEMBERSHIP

SECTION I. MEMBERS. The Advisory Council shall consist of eight (8) members appointed by the Director with approval of the Governor. Persons selected for membership on the Advisory Council shall be chosen to allow for broad representation of population groups to be served, of governmental and employee groups, local citizens' groups, and representatives of major socio-economic and ethnic groups.

SECTION II. TENURE. Members shall serve at the pleasure of the Governor. Three consecutive absences from regular meetings shall require automatic recommendation, to the Director, for removal of that member from the Advisory Council. The member shall be notified in writing of the recommendation.

SECTION III. REIMBURSEMENT. Each member is entitled to be reimbursed for expenses at the same rate as provided for State employees. Sections 59-538, 59-539, 59-801 R.C.M., 1947.

SECTION IV. HONORARIUM. All members who are not full time salaried officers or employees of Montana or any political subdivision of this State are entitled to be paid twenty-five dollars ($25) for each day actually and necessarily engaged in the performance of Council duties.

ARTICLE IV

MEETINGS

SECTION I. MEETINGS. Mettings shall be held at least quarterly, and at other times upon the call of one or more of the following: Director of the Department of Institutions, Chairman of the Advisory Council, or a majority of tne Council members. Meetings must be held in Helena unless prior authorization is given.

SECTION II. NOTICE. Notice of all meetings shall be sent by mail to the entire membership by the Director at least two weeks in advance of the meeting.

SECTION III. QUORUM. A majority of the membership constitutes a quorum to do business. In any case wherein a member of the Council attending a Council business meeting and must leave during the course of the meeting, he may delegate a proxy vote, in writing, to another member for that meeting only during his absence, otherwise, no proxy vote will be allowed.

SECTION IV. CONDUCT OF MEETINGS. The Chairman shall preside at all meetings and the meetings shall be conducted in accordance with the current Roberts' Rules of Order.

ARTICLE V

OFFICERS

SECTION I. OFFICERS. The Council shall, at its first meeting each fiscal year, elect a chairman and vice chairman. Officers must be elected by a majority vote. Term of office shall be one year. Officers may hold successive terms.

SECTION II. QUALIFICATIONS. All members are eligible to be elected to office.

SECTION III. VACANCY. A vacancy in an office shall be filled by a majority vote of the membership for the remainder of the term of office.

ARTICLE VI

DUTIES

The duties of the Council are:

a) Review and make specific recommendations to be considered in the Montana State Comprehensive Plan for the prevention, treatment and control of alcohol abuse, alcoholism, drug abuse, and drug addiction.

b) Generally advise the Department in the conduct of its comprehensive planning and evaluation activities and in setting of priorities.

c) Review and make recommendations on all receipts and expenditures of all grant monies.

ARTICLE VII

AMENDMENTS

Changes and amendments to the by-laws of the Council may be made at any regular meeting by a vote of the majority of the total membership of the Council provided that written notice of a proposed change is given at least two (2) weeks in advance of a meeting.

Reference: Section 82A-110, R.C.M. 1947.

PL 616, Sec. 303(3), (84 Stat. 1850)

PL 92-255, Sec. 409(c)(2), (e)(3) (86 Stat. 82)

Agendas and minutes of all Advisory Council meetings are mailed to:

1. Alcohol and Drug Advisory Council members.
2. All alcohol and drug programs in Montana.
3. Alcohol Programs of Montana, Inc.
4. Region VIII, Denver
5. All state agencies and residents requesting to be included on our mailing list.

MONTANA STATE PLAN FY 76

MINUTES

of

ALCOHOL & DRUG ADVISORY COUNCIL

The Advisory Council met in the Department of Institutions Conference Room, Helena, Montana.

The meeting was called to order at 9:00 a.m., April 30, 1976.

Members Present:

Robert L. VanHorne, Ph.D. - Chairman
Rep. Martha Herlevi - Vice Chairman
Peggy Skelton
Sharon Pettit
Larry Fasbender
Gary Hall

Members Absent:

Katherine Hanrahan
Carl Kipp

Staff:

Mike Murray, Chief, Addictive Diseases Bureau
Robert W. Anderson, Project Manager
George Swartz, Drug Coordinator
Fred Barta, SMDP
Paul Babbitt, Alcohol Coordinator
Norma Jean Murphy, Health Educator
Bob Gwaltney, Training Officer
Terry Stancliff, STSP Coordinator

The Advisory Council minutes of the March 22, 1976 meeting at Billings were approved as mailed.

The following change in the By-Laws was moved by Martha Herlevi, seconded by Gary Hall, and passed unanimously:

SECTION III. REIMBURSEMENT. Each member is entitled to be reimbursed for expenses at the same rate as provided for State employees. Sections 59-538, 59-539, 59-801 RCM, 1947.

9:30 a.m. - The Advisory Council divided into various Task Force committees to review the Alcohol grant applications. The [illegible] and technical assistant to each application and [illegible] review.

5:30 p.m. Meeting adjourned.

9:00 a.m., May 1, 1976 - Advisory Council Task Force Committees and Staff Technical Assistant resumed reviewing the alcohol grant applications. The reviews were completed at 11:00 a.m.

The Advisory Council then met as a whole, in the conference room of the Department of Institutions. Jim Foley was present for part of this portion of the meeting.

Council members, by consensus, established the following priorities for each alcohol application using the following criteria:

1st Comprehensive alcohol programs that received state "909" funding last year (FY'76).

2nd Applicants that will offer comprehensive alcohol services during the proposed grant year (FY'77).

3rd Applicants that will offer only limited alcohol services during the grant period (FY'77) and did not receive funding during FY'76, i.e., programs that proposed services of a singular nature, education, prevention, intermediate, outpatient, or services only a single age group or population.

4th 4th priority (temporarily established) for those grant applications that applied for funds, but in the opinion of staff and council do receive adequate funding from other tax supported agencies.

Billings Deaconess Hospital was switched from 3rd to 1st priority because Council Members agreed that the application was an expansion of what was funded and operated by Rimrock Guidance Foundation last year; passed unanimously by vote.

Grants were reviewed by Council to reassess all priorities. Addictive Diseases Bureau staff member, responsible for Technical Assistance, presented a brief report on history, etc. of each program and advised the Council of the Task Force Committee recommendation for each application.

Program	Priority
Rosebud County, Forsyth	1st
Shelby Middle School, Shelby	3rd
Rimrock Guidance Foundation, Billings	1st
[illegible] Agency	4th
Billings Deaconess Hospital	1st
Alcohol Service Center of Lincoln County, Libby	1st
Great Falls City County Health Department	1st
Alcohol Rehabilitation Association, Helena	1st
Hill Co. Recovery Center, Havre	1st
Missoula City/County Health Department	1st
[illegible] County, Deer Lodge	2nd
District [illegible], Plentywood	2nd
Blackfeet Reservation, Browning	1st
North West Mont. Alcohol Program, Kalispell	1st

Program	Priority
Deer Lodge County, Anaconda	1st
District II, Glendive	1st
Mont. Employee Assistance Program, Missoula	3rd/1st
Flathead Reservation, Ronan	1st
Billings Indian Center	3rd - Disapproved
Denny Driscoll Boys' Home, Butte	3rd
Coordinated Youth Center, Colstrip	3rd
Fort Peck Tribal Alcohol Program, Poplar	2nd
Custer County Alcohol Program, Miles City	1st
Northern Cheyenne Alcohol Program, Lame Deer	3rd - Disapproved
Fort Belknap Alcohol Program, Harlem	2nd

Council and staff members totaled the cost/priority for requested funding:

Priorities	Costs
1st	$723,050.00
2nd	30,019.34
3rd	73,692.96
4th	30,275.00
Total:	$857,037.31

Council members discussed cuts to grant applications on a percentage basis: over $100,000 cut 15%; over $50,000 cut 10%.

Council members discussed the need and merit of moving Crow Agency and Blackfeet programs up to 2nd priority and fund each $10,000 per grant as requested in application.

A motion was made by Peggy Skelton, that with the exception of Colstrip, to eliminate all 3rd priority programs pending availability of funds; seconded by Martha Herlevi. (No vote) A sub-motion was made by Larry Fasbender: In the event during FY'77 funding is available to fund 3rd priorities, program applications will be re-evaluated by Advisory Council members to establish need. If Council agrees with need, priority for funding 3rd priority applications will be established by Council. Seconded by Gary Hall, and passed. Original motion passed.

Peggy Skelton moved that Colstrip, Crow Agency, and Blackfeet applications be moved to priority 1 and fund each:

Crow Agency	$10,000
Blackfeet	$10,000
Colstrip	$13,110

Martha Herlevi seconded the motion and it was passed.

Recommendation [illegible] Staff and [illegible] Alcohol and Drug Advisory [illegible] priority [illegible] alcohol programs in [illegible] as follows:

Program	Council Recommendation
Blackfeet Guidance Foundation	$116,178.00
Billings Deaconess Hospital	50,000.00
Deer Lodge County, Anaconda	8,687.34
District II, Glendive	30,000.00
Alcohol Service Center of Lincoln County, Libby	10,200.00
Crow Agency	10,000.00
Missoula City/County Health Department	27,950.65
District I, Plentywood	58,906.69
Mont. Employee Assistance Program, Missoula	1,516.66/per mo.
Rosebud County, Forsyth	9,633.33
Hill-Top Recovery Center, Havre	82,250.00
Fort Peck Tribal Alcohol Program, Poplar	10,019.34
Fort Belknap Alcohol Program, Harlem	6,000.00
Northwest Mont. Alcohol Program, Kalispell	52,000.00
Flathead Reservation, Ronan	15,180.00
Coordinated Youth Center, Colstrip	13,110.00
Alcohol Rehabilitation Association, Helena	70,000.00
Powell County, Deer Lodge	14,000.00
Blackfeet Reservation, Browning	20,275.00
Great Falls City/County Health Department	180,000.00
Custer County, Miles City	12,064.00

The Hill-Top application was discussed, and Dr. VanHorne stated counties need staff decisions before the final dollar amount of applications could be determined.

In adjusting the amounts, Larry Fasbender suggested a sliding scale cut. However, the motion was made by Peggy Skelton that the Advisory Council recommend that the good judgment of the staff be utilized in cutting funding to the appropriate amount. Gary Hall seconded the motion and it was passed.

The May meeting was discussed and it will be in Helena, May 25, 1976. The agenda will include 1) the Drug Plan and a complete report of activities, and 2) a report on alcohol funding.

The Advisory Council will be available to the call of the chair during the months of June, July, and August, but regular meetings will not be scheduled. Motion was made by Gary Hall, seconded by Larry Fasbender and passed unanimously.

A motion was made by Larry Fasbender and seconded by Gary Hall to approve the Drug Plan as presented. Motion was passed.

The problem of attendance or lack thereof was discussed by Council members. Council decided that a quorum of members present would be the majority of those not absent. The meeting would not count for attendance purposes. Members also stated that Section of the By-Laws is (3) months, members pointed out many times absences have been excused with reasons. Council members discussed Carl Kipp's lack of attendance at any council meetings and

decided to write him and determine his intentions about serving on the Council.

The meeting was adjourned at 2:45, May 1, 1976.

SECTION 5

5.1 LISTING OF ALCOHOLISM SERVICE PROVIDERS AND COMPONENTS OF SERVICE PROVIDED

5.2 MENTAL HEALTH REGIONS

5.3 MENTAL HEALTH BOARDS, STAFF AND ADVISORY COUNCIL MEMBERS

5.4 COPY OF CONTRACT SIMILAR TO THOSE USED WITH THE FIVE REGIONAL BOARDS

MONTANA STATE PLAN FY 76

CURRENT ALCOHOLISM SERVICES IN THE MENTAL HEALTH REGIONS

REGION I

COUNCIL OF COUNTIES - District I - This group of 5 counties provide referral and outpatient counseling services. They are operating on $40,829 from the SAA and revenue sharing funds from the participating counties. The service area is the 5 counties in the northeast corner of the State.

COUNCIL OF COUNTIES - District II - This is a group of four counties in the eastern central portion of the state. They provide referral and outpatient counseling. Their funding from the SAA is $28,200 with additional funds from county revenue sharing from the four counties.

FORT PECK RESERVATION ALCOHOLISM PROGRAM - This program serves the reservation Indians at Poplar. A comprehensive range of service if offered, which includes detoxification, intermediate care, counseling, outreach, prevention, thrift shop, information and referral. Sources of funding include: IHS - $68,200, NIAAA -$33,200 and supplemental NIAAA - $24,000. The total level of funding is $125,400.

REGION I (continued)

COLSTRIP YOUTH PROJECT - This program located in the high impact coal area of southeastern Montana provides referral and outpatient counseling to high school age youth. It is funded with county revenue sharing funds, NIDA funds through the SDA, Voc Rehab and $9,750 from the SAA. Service area is primarily the town of Colstrip.

CUSTER COUNTY - The County Health Department operates a referral and outpatient counseling service. This county program has received $9,500 from the SAA and has additional funds from county revenue sharing. The service area is Custer County.

NORTHERN CHEYENNE ALCOHOLISM PROGRAM - This program serves the reservation Indians of Lame Deer. A comprehensive range of service is offered which includes: detox, intermediate care, counseling, outreach, information and referral. The sources of funding are: IHS - $37,800 and NIAAA - $54,000. The total level of funding is $91,800.

ROSEBUD COUNTY - The County Health Department operates a referral and outpatient counseling service. They are receiving $4,636 from the SAA and also utilize county revenue sharing. The service area is the county.

REGION II

GREAT FALLS - The City-County Health Department operates a comprehensive range of services. This includes intermediate care, inpatient treatment, outpatient, follow-up, education and prevention. Detox is available on a limited basis. These services are provided on a contractual arrangement. This community program received $148,529 in funding from the State Alcohol Authority. They also have additional funding from City and County revenue sharing, Vocational Rehabilitation fees for service. They serve primarily the residents of Cascade County.

HILLTOP RECOVERY CENTER - Havre - This program provides detox, inpatient treatment, intermediate, outpatient, referral education and prevention for seven counties in the North Central portion of the State. They have received $54,700 from the SAA and receive revenue sharing funds from each of the seven counties served. In addition, they have some United Givers and City revenue sharing funds and fees for service.

FORT BELKNAP ALCOHOLISM PROGRAM - This program serves the reservation Indians at Harlem. A comprehensive range of service is offered which includes detoxification at the Indian Health Hospital, intermediate care, counseling, information and referral. The sources of funding are: IHS - $45,280 and NIAAA - $42,964. The total level of funding is $88,244.

REGION II (continued)

ROCKY BOY ALCOHOLISM PROGRAM - This program serves the reservation Indians at Box Elder. A comprehensive range of service is offered, which includes detoxification, intermediate care, counseling, information and referral. The sources of funding are: IHS - $33,600 and NIAAA - $30,000. The total level of funding is $63,600.

BLACKFEET ALCOHOLISM PROGRAM - This program serves the reservation Indians at Browning. A comprehensive range of service is offered, including detox, outpatient, counseling, prevention, rehabilitation, information and referral. The sources of funding are: IHS - $47,000 and NIAAA - $40,000. Total level of funding - $87,700.

REGION III

BILLINGS - The Rimrock Guidance Foundation is the agency providing alcohol services. This agency provides detox services through a contract with the Deaconess Hospital. Rimrock provides intermediate care for both male and female, outpatient, follow up, education, prevention and referral. In patient treatment capability is being developed and will be operational soon. This program received $42,656 from the SAA for the current fiscal year. They also receive a significant amount of funding from the United Givers and from client fees.

REGION III (continued)

CROW RESERVATION ALCOHOLISM PROGRAM - This program serves the reservation Indians at Crow Agency. A comprehensive range of service is offered, which includes: detoxification, counseling, information and referral. The sources of funding are: IHS - $47,400 and NIAAA - $30,000. The total level of funding is $77,400.

ALCOHOL REHABILITATION ASSOCIATION - Helena - This program provides detox, outpatient counseling, referral, education and prevention in ten Southwestern Montana counties. They are funded with a Federal Staffing grant, County revenue sharing, United Givers, Voc. Rehab. and $60,609 from the SAA.

GALEN ALCOHOL TREATMENT CENTER - This program is State operated and provides detox and inpatient treatment for residents of the State.

FRONTIER ALCOHOLISM PROGRAM - Dillon - This program provides detox, referral and outpatient counseling for the residents of Beaverhead County. It is funded with County and City revenue sharing funds and $30,000 from the SAA.

NORTH AMERICAN INDIAN ALLIANCE - This program serves the urban Indians within the City of Butte. Services offered include information and referral, education and counseling (individual and family). The source of funding is NIAAA - $42,328.

REGION IV (continued)

DEER LODGE COUNTY - This county program provides referral and outpatient counseling for the residents of Anaconda and the county. It is funded with county revenue sharing money and $15,795 from the SAA.

BOYD ANDREWS' GUEST HOUSE - Helena - This is a twelve step house providing residence for five clients. They provide referral and counseling.

REGION V

NORTHWEST MONTANA ALCOHOL PROGRAM - Kalispell - This program serves Flathead and Lincoln counties, provides referral, outpatient counseling, education and prevention. They have been funded with $42,411 from the SAA and also have county revenue sharing, united givers, fees for service, Vocational Rehabilitation and CETA.

FLATHEAD ALCOHOLISM & DRUG ABUSE PROGRAM - This program serves the reservation Indians at Ronan. They also operate an information and referral service in Sanders County. A comprehensive range of service is offered, which includes detox, intermediate care, counseling, outreach, follow-up, prevention, education, information and referral. The tribe recently donated a new building to house the program's detox and intermediate care components. Sources of

REGION V (continued)

funding include: IHS - $50,728, NIAAA -$29,000 and NIAA - $135,000. The total level of funding is $214,728.

MISSOULA INDIAN ALCOHOL & DRUG SERVICES - This program serves urban Indians within the City of Missoula. Services offered include information, referral and counseling. The source of funding is NIAAA - $64,000.

MONTANA STATE PLAN FY 76

ALCOHOL PROGRAMS

Bob McKinnon, Acting Director
Alcoholism Rehabilitation Assn.
of Southwestern Montana
324 Fuller
Helena, Montana 59601

John Horton, Director
Bozeman Problem Drinking Center
104 East Main - Room 316
Bozeman, Montana 59715

Jim Weiss, Director
Deer Lodge County Alcohol Program
6th & Oak Streets
Anaconda, Montana 59711

Bob McKinnon, Acting Director
Frontier Halfway House
1100 Atlantic
Dillon, Montana 59725

Jerry Krusemark, Counselor
Park County Alcohol & Drug Program
Livingston, Montana 59047

Don Holmes, Director
Alcohol Treatment & Rehabilitation
Program
Galen State Hospital
Galen, Montana 59711

Brian DeRoches, Director
Rimrock Guidance Foundation
804 North 29th Street, Suite, 201
Billings, Montana 59101

Steve Polland, Director
Custer County Alcohol Program
Custer County Courthouse
Miles City, Montana 59301

Jon Tovson, Director
Cascade County Alcohol Program
1730 17th Avenue South
Great Falls, Montana 59401

Ron Hjelmstad, Director
Provisional Council for District I
Sheridan County Courthouse
Plentywood, Montana 59254

Jack Pollari, Director
District II Alcohol Program
P.O. Box 281
Glendive, Montana 59330

Boyd Andrew
Boyd Andrew's Guest House
12 Step Recovery House
410 9th Avenue
Helena, Montana 59601

Marie Morton
Missoula City-County Health Dept.
Courthouse Annex
Missoula, Montana 59801

Northwest Montana Alcohol & Drug
Information & Referral
945½ 4th Avenue East
Kalispell, Montana 59901

Richard Baumberger
Providence Resocialization Center
920 4th Avenue North
Great Falls, Montana 59401

Bob MacConnel, Alcoholism Counselor
Rosebud County
P.O. Box 338
Forsyth, Montana 59327

Mary Alice Rehbein
District II Alcoholism Program
P.O. Box 868
Sidney, Montana 59270

ALCOHOL PROGRAMS (continued)

Danny Peressini, Director
Hill-Top Recovery Center
1020 Assiniboine
Havre, Montana 59501

Blackfeet Tribal Alcoholism Program
P.O. Box 251
Browning, Montana 59417

Harold Campbell
Flathead Alcoholism & Drug
Abuse Information Center
P.O. Box 270
Ronan, Montana 59847

Mary Kendall
Great Falls Indian Education Center
P.O. Box 2532
Great Falls, Montana 59401

Leo Pocha
Helena Indian Alliance
P.O. Box 1196
Helena, Montana 59601

Carolyn O'Neill
North American Indian Alliance
Alcohol Services
72 East Park Plaza
Butte, Montana 59701

Billings American Indian Council
Urban Indian Alcoholism Center
23 South 27th Street
Billings, Montana 59101

Crow Reservation Alcoholism
Program
Crow Agency, Montana 59022

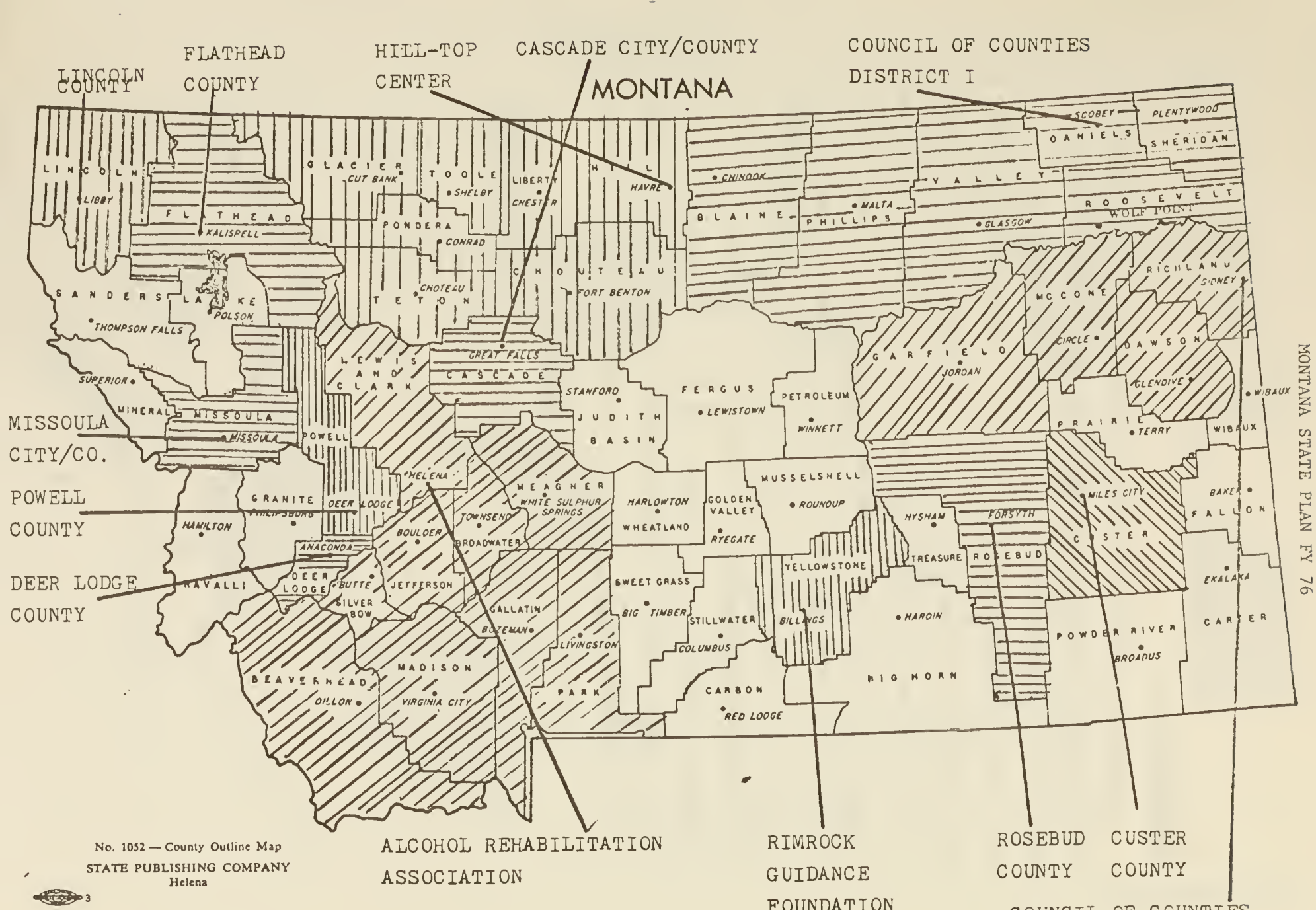
Fort Belknap Tribal Alcoholism
Program
Harlem, Montana 59526

Melvin Eagleman
Fort Peck Reservation
Alcoholism Program
P.O. Box 307
Poplar, Montana 59255

Willie Wineberger
Missoula Indian Alcohol &
Drug Services
P.O. Box 1197
Missoula, Montana 59801

Northern Cheyenne Reservation
Alcoholism Program
P.O. Box 173
Lame Deer, Montana 59043

Rocky Boy Tribal Alcoholism
Program
Rocky Boy Route
Box Elder, Montana 59521



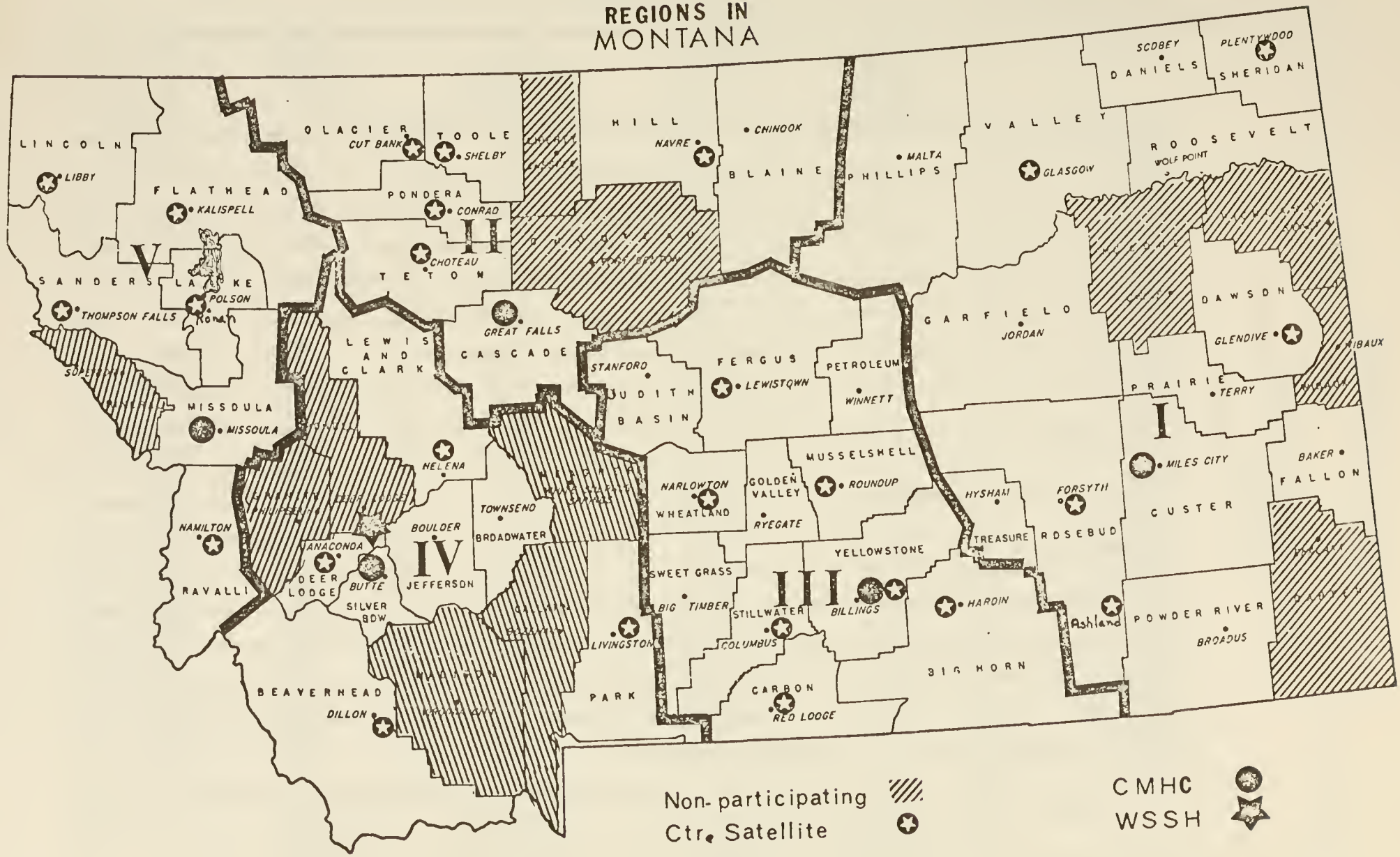
No. 1052 — County Outline Map
STATE PUBLISHING COMPANY
Helena

3

Alcohol and Drugs

Coordination between mental health program planning and alcohol and drug abuse program planning occurs within the Adaptive Services Dvision (ASD) of the Department of Institutions. As displayed on Exhibit X Bureau Chiefs for both programs report directly to the ASD Administrator. Weekly management meetings are held to plan activities, work out solutions to mutual problems and report on progress toward achievement of objectives. As previously discussed, the ASD role in administration of mental health, alcohol and drug abuse programs is primarily monitoring of community-based service delivery. Emphasis is being placed on Regional Mental Health Boards assuring increasing responsibility for administration of broader service programs. As a result, each of the five Regional Boards will review and comment on State Plans for Alcohol and Drug Abuse for Fiscal Year 1977. These Plans will be developed into five sections, one for each geographic region, to meet unique regional needs.

MENTAL HEALTH REGIONS IN MONTANA



Non-participating

Ctr. Satellite

CMHC

WSSH

NOVEMBER, 1975

MENTAL HEALTH REGION I
(17 Counties)

County	Governor's Planning Region	TOTALS 1970 Pop.	Indian Pop. 1970 Census	Est. 8.5% Alcohol Abusers	Area In Sq. Mi.
Carter	3	1956	3	166	3313
Custer	3	12174	65	1035	3775
Daniels	1	3083	16	262	1443
Dawson	2	11269	50	958	2380
Fallon	3	4050	13	344	1633
Garfield	2	1796	——	153	4812
McCone	2	2875	17	244	2652
Phillips	1	5386	258	458	5287
Powder River	3	2862	34	243	3298
Prairie	2	1752	13	149	1739
Richland	2	9837	40	836	2103
Roosevelt	1	10365	3110	881	2399
Rosebud	3	6032	1820	513	5042
Sheridan	1	5779	42	491	1720
Treasure	3	1069	1	91	997
Valley	1	11471	972	975	5104
Wibaux	2	1465	——	125	891
TOTALS		93221	6454	7924	48588
1.9 Persons Per Sq. Mi.					

MENTAL HEALTH REGION II
(9 Counties)

County	Governor's Planning Region	TOTALS 1970 Pop.	Indian Pop. 1970 Census	Est. 8.5% Alcohol Abusers	Area In Sq. Mi.
Blaine	4	6727	1562	572	4279
Cascade	5	81804	1509	6953	2673
Chouteau	5	6473	153	550	3936
Glacier	5	10783	4576	917	3006
Hill	4	17358	1607	1475	2946
Liberty	4	2359	9	200	1459
Pondera	5	6611	546	562	1654
Teton	5	6116	45	520	2310
Toole	5	5839	63	496	1965
TOTALS		144070	10070	12245	24228

5.9 Persons Per Sq. Mi.

MENTAL HEALTH REGION III
(11 Counties)

County	Governor's Planning Region	TOTALS 1970 Pop.	Indian Pop. 1970 Census	Est. 8.5% Alcohol Abusers	Area In Sq. Mi.
Big Horn	7	10057	3917	854	5055
Carbon	7	7080	29	602	2074
Fergus	6	12611	65	1072	4253
Golden Valley	6	931	1	79	1180
Judith Basin	6	2667	7	227	1880
Musselshell	6	3734	2	317	1887
Petroleum	6	675	2	57	1672
Stillwater	7	4632	23	394	1801
Sweet Grass	7	2980	2	253	1849
Wheatland	6	2529	17	215	1425
Yellowstone	6	87367	1063	7426	2666
TOTALS		135263	5130	11496	25742
5.3 Persons Per Sq. Mi.					

MENTAL HEALTH REGION IV
(12 Counties)

County	Governor's Planning Region	TOTALS 1970 Pop.	Indian Pop. 1970 Census	Est. 8.5% Alcohol Abusers	Area In Sq. Mi.
Beaverhead	12	8187	31	696	5580
Broadwater	8	2526	22	215	1245
Deer Lodge	12	15652	240	1330	741
Gallatin	9	32505	99	2763	2540
Granite	12	2737	20	233	1737
Jefferson	8	5238	64	445	1654
Lewis & Clark	8	33281	486	2829	3513
Madison	12	5014	78	426	3541
Meagher	9	2122	12	180	2356
Park	9	11197	32	952	2613
Powell	12	6660	98	566	2340
Silver Bow	12	41981	359	3568	716
TOTALS		167100	1541	14203	28576

5.8 Persons Per Sq. Mi.

MENTAL HEALTH REGION V
(7 Counties)

County	Governor's Planning Region	TOTALS 1970 Pop.	Indian Pop. 1970 Census	Est. 8.5% Alcohol Abusers	Area In Sq. Mi.
Flathead	10	39460	327	3354	5280
Lake	10	14445	2199	1228	1655
Lincoln	10	18063	209	1535	3728
Mineral	11	2958	16	251	1223
Missoula	11	58263	660	4952	2624
Ravalli	11	14409	142	1225	2388
Sanders	11	7093	384	603	2819
TOTALS		154691	3937	13148	19717
7.8 Persons Per Sq. Mi.					

EASTERN MONTANA (REGION I) MENTAL HEALTH CENTER

Administrative Office:
Executive Building
11 South 7th Street
Miles City, MT 59301
Telephone: 232-1687 (Hotline 133-29)

Counties Served: Custer, Garfield, Fallon, Carter

Office Staff:
Frank Lane, M.A., Acting Administrative Director
Don Hay, M.D., Psychiatrist, Medical/Clinical Supervisor
Sister Corita Dickinson, M.H.A., M.S.N., Psychiatric Nurse
Judy Gudmundson, A.D.N., Psychiatric Nurse
Sandra Paggen, A.D.N., Psychiatric Nurse
Richard Kerstein, M.A., Psychologist
Cindy Radue, O.T.R., Occupational Therapist
Eleanor Heiser, Business Office
Patty Lavin, Mental Health Worker
Paula Newstrom, Mental Health Worker
Connie Myran, Secretary
Lillian Mankameyer, Secretary
Judi Adams, Secretary
Bernice Geist, Clerk-typist

Satellite Offices:

ASHLAND
St. Labre Indian School
Ashland, MT 59003
Telephone: 784-2737

Counties Served: Rosebud (southern half), Powder River

Office Staff:
Ned Tranel, Ph.D., Clinical Psychologist
John Higgins, B.A., Social Worker
Pearl Nation, Mental Health Worker
Virginia Tranel, Secretary

FORSYTH
Old Hospital Building, 17th Street
Forsyth, MT 59327
Telephone: 356-7654

Counties Served: Rosebud, Powder River, Treasure

Office Staff: Ron Mogen, M.A., Psychologist

GLASGOW
442 3rd Avenue N.
Glasgow, MT 59230
Telephone: 228-9349

Counties Served: Valley, Roosevelt, Phillips

Office Staff:
Dr. John Waterman, Psychiatrist
Bill Jones, M.A., Psychologist
Rachel Crossan, Secretary
Patsy Walker, Clerk-typist
Marty Jones, Psychologist
Mrs. Waterman, Social Worker

Eastern Montana (Region I) Mental Health Center - Satellite Offices (continued)

PLENTYWOOD
108 East 1st Avenue
Plentywood, MT 59254
Telephone: 765-2550

Counties Served: Sheridan, Daniels, East Roosevelt

Office Staff: William McFarren, M.A., Psychologist

GLENDIVE
Glendive Medical Center
Glendive, MT 59330
Telephone: 365-2922

Counties Served: Dawson, Wibaux, McCone, Richland, Prairie

Office Staff: Larry Olson, Ed.D., Psychologist
Robert Hemme, Psychologist
Judi Price, Secretary

Eastern Montana (Region I) Mental Health Board

President: George Knudsen (Phillips County)
P.O. Box 359
Malta, MT 59538
Telephone: 654-2320 (Office)
654-1224 (Home)

1st Vice President: Al Mathison (Dawson County)
311 South Taylor Avenue
Glendive, MT 59330
Telephone: 365-4286

2nd Vice President: R.C. Denson (Powder River County)
Powder River County courthouse
Broadus, MT 59317
Telephone: 436-2657

Secretary: John Maxness (Valley County)
Fort Peck Route
Glasgow, MT 59230
Telephone: 228-4713 (Courthouse)
367-4230 (Home)

Treasurer: Ethel Bond (Prairie County)
Terry, MT 59349
Telephone: 637-5570
637-5469 (Home)

Other Members:

Morris Billehus (Daniels County)
P.O. Box 384
Scobey, MT 59263
Telephone: 487-2869

John Moreland (Rosebud County)
County Courthouse
Forsyth, MT 59327
Telephone: 356-2251
984-2575 (Home)

Eastern Montana (Region I) Mental Health Board (continued)

Lester Engdahl (Garfield County)
Jordan, MT 59337
Telephone: 435-2225

Vic Kosty (Custer County)
P.O. Box 567
Miles City, MT 59301
Telephone: 232-1347 (Courthouse)
232-2754 (Store)

George Stensland (Roosevelt County)
Wolf Point, MT 59201
Telephone: 653-1322

Kenneth Rustad (Fallon County)
P.O. Box 246
Baker, MT 59313
Telephone: 778-2228 (Courthouse)
588-2137 (Home)

Ernie Icapini (Treasure County)
County Courthouse
Hysham, MT 59038
Telephone: 342-5547 (Courthouse)
342-5325 (Home)

Ray Stoner (Sheridan County)
Outlook, MT 59252
Telephone: 895-3576
895-2233 (Home)

Tom Sylvester, Administrator
Fallon County Memorial Hospital
Baker, MT 59313
Telephone: 778-3331

Morine Anderson (Carter)
Ekalaka, MT 59324
Telephone: 775-2141 (Home)

Non-participating Counties

Board Members are yet to be designated from:
------Wibaux County
------McCone County
------Richland County

NORTH CENTRAL MONTANA (REGION II) MENTAL HEALTH CENTER

Administrative Office:
Box 2717, Holiday Village
Great Falls, MT 59403
Telephone: 761-2100 (Hotline 124-38)

Counties Served: Cascade, Teton, Pondera

Office Staff:
Evan S. Crandall, Administrative Director
Galen A. Wilson, Psychiatric Social Worker
Robert M. Fry, Psychiatric Social Worker
Andree Deligdisch, Psychiatric Social Worker
Gene Freeman, Psychiatric Social Worker
Rich Davis, Occupational Therapist
Charles Jones, Clinical Psychologist
Rex Haire, Psychologist
Dr. Hamilton Pierce, Psychiatrist
Charles Hiber, M.A., A.C.S.W., Clinical Social Worker
Ken Klevin, M.S.W., Psychiatric Social Worker
Arline Carhill, Social Worker
Paul Kitzhaeber, Social Work Aide
Jeanne Adams, Social Worker
Deljean McNutt, Social Worker
Dr. George Gerlenter, Psychiatrist (part-time)
Everett Maxwell, Outreach Worker
Rose Mary Lamere, Outreach Worker
Dick Hruska, Business Manager
David Crow, Statistician
Carole Ferda, Vista Volunteer
Fern Anderson, Vista Volunteer
Margo Bennyhoff, Vista Volunteer
Theresa Curtis, Vista Volunteer
Edith Houle, Vista Volunteer
Pearl (Sue) Crandall, Secretary
Sue Marchidon, Secretary
Jo An Maeder, Secretary
Patricia Chamberlain, Secretary
Candy Ashmore, Secretary
Marlys Mangols, Secretary
Sandy Raucci, Clerk
Kathy O'Connor, File Clerk

Satellite Offices:

HAVRE
Northern Montana Hospital, East
Box 1658
Havre, MT 59501
Telephone: 265-9639 (Hotline 135-201)

Counties Served: Hill

Office Staff:
Marcus Brown, Psychiatrist
Dr. Monte Kuka, Psychologist
Leonard Kemp, M.S.W., Psychiatric Social Worker
Shirley McAllister, Secretary

North Central (Region II) Mental Health Center - Satellite Offices (continued)

CUTBANK
Memorial Hospital
706 Second Street, S.E.
Cutbank MT 59427
Telephone: 938-4138

Counties Served: Glacier

Office Staff: Robert Wolfe, Psychiatric Social Worker
Thelma Bjorklund, Secretary

SHELBY
220 Main Street
Shelby, MT 59474
Telephone: 434-5285

Counties Served: Toole

Office Staff: Larry Burman, Psychologist
Telephone: 434-5852 (Home)
Loretta Macrow, Secretary

CONRAD
Box 1453
Conrad, MT 59425
Telephone: 278-3205

Counties Served: Pondera

Office Staff: Dick Wimmers, Psychologist
Virginia Dickey, Secretary

CHOTEAU
Box 100
19 Third Avenue N.E.
Choteau, MT 59422
Telephone: 466-5681

Counties Served: Teton

Office Staff: Steve Schulman, Psychologist
Connie Bullis, Secretary

North Central (Region II) Mental Health Board

Chairman: John Nesbo (Toole)
County Commissioners Office
Box 411
Shelby, MT 59474
Telephone: 434-2332

Vice-Chairman: Leonard Johnson (Pondera)
Box 65
Brady, MT 59416
Telephone: 278-3226 (Office)
278-3185 (Home)

Secretary-Treasurer: Larry Fasbender (Cascade)
County Commissioners Office
Cascade County Courthouse
Great Falls, MT 59401
Telephone: 761-6700, Ext. 314 (Office)
264-2425 (Home)

North Central (Region II) Mental Health Board (continued)

Roy Goodell (Teton)
County Commissioners Office
Choteau, MT 59422
Telephone: 466-2151 (Office)
463-2453 (Home-Dutton)

John H. Stephens (Blaine)
County Commissioners Office
Chinook, MT 59523
Telephone: 357-3250 (Office)
357-2695 (Home)

Robert Pester (Hill)
County Commissioners Office
Havre, MT 59501
Telephone: 265-7813 (Office)

William McAlpine (Glacier)
County Commissioners Office
Cutbank, MT 59427
Telephone: 938-4722 (Office)
336-2240 (Home)

Darrell Smith (Alternate-Glacier)
402 4th St. S.E.
Cutbank, MT 59427
Telephone: 338-2891

Non-Participating Counties

Dale Skaalure (Choteau)
County Commissioners Office
Courthouse
Fort Benton, MT 59442

Troy Lakey (Liberty)
Whitlash, MT 59545
Telephone: 432-2551

SOUTH CENTRAL MONTANA (REGION III) MENTAL HEALTH CENTER

Administrative Office:
1245 North 29th Street
Billings, MT 59101
Telephone: 252-5658 (Hotline 122-2354)
252-5650 (After 5:00)

Counties Served:
Yellowstone, Big Horn, Carbon, Stillwater, Sweet Grass, Wheatland, Musselshell, Petroleum, Fergus and Judith Basin

Office Staff:
Bryce G. Hughett, M.D., Reg. Mental Health Director
Duncan D. Burford, M.D., Psychiatrist (hourly only)
Donald L. Harr, M.D., Psychiatrist (hourly only)
Joseph Rich, M.D., Psychiatrist (hourly only)
John R. Taylor, M.A., Psychologist VI/Asst. to Dir.
Kenneth Collier, Ed.D., Psychologist VI/Ed. Cons. Spec.
Marian F. Martin, Ph.D., Psychologist V/Child. Ser. Dir.
Linda Baskett, Ph.D., Psychologist V/R. & Eval. Dir.
Robert Tompkins, Ed.D., Psychologist V
Mary Honaker, R.N., Psy. Nurse IV/Day Care Dir.
Sharon Harris, R.N., M.N., Psy. Nurse IV/Geriatrics Director - (part-time)
Margaret Dasinger, M.S., Teacher, Ungraded Rm., III
Irene Restad, OTR, B.A., B.S., Occup. Therapist II
Gary Bounous, MSW, ACSW, Soc. Services Dir.-(part-time)
Alice Rupp, MSW, ACSW, Psych. Social Wkr. III
Jon Vodden, MSW, ACSW, Psych. Social Wkr. III
David Pierce, MSW, Psych. Social Wkr. II
Carla Teigen, B.A., Social Wkr. III/Aftercare
Helen Huennekens, M.S., Mental Health Wkr. IV
Jani McCall, M.S., Mental Health Wkr. IV
John Noteboom, B.A., Mental Health Wkr. IV
David Rodriguez, B.A., Mental Health Wkr.
Valorie Everton, B.S., Mental Health Wkr. IV
Sue Heisel, B.S., Mental Health Wkr. IV/Inpatient Coord.
Jan Larsen, B.A., Mental Health Wkr. III
Jeanne Fisher, B.S., Business Manager II
Frances Davis, Accountant I
Pearl Anderson, Secretary III - (part-time)
Lorraine Barkley, Secretary III
ElRene Dorn, M.S., Secretary III
Diane J. Taylor, A.A., Administrative Asst. II
Kathy Brophy, Statistical Tech. II
Bonnie Womeldorf, Secretary I

Satellite Offices:
Neighborhood Counseling Center
2718 Montana Avenue, Room #10
Billings, MT 59101
Telephone: 252-6518

Office Staff:
Judy Morris, Mental Health Wkr. IV
Mary Jo Shaw, Secretary I

South Central Montana (Region III) Mental Health Center - Satellite Offices (continued)

COLUMBUS

Stillwater Community Hospital
Columbus, MT 59010
Telephone: 322-5834

Office Staff:

David T. Beans, M.S., Psychologist III
Betty Ann Roan, Secretary III (part-time)

Counties Served:

Stillwater and Sweet Grass

HARDIN

619 West Division
Hardin, MT 59032
Telephone: 665-1049

Office Staff:

Steve Mincer, A.M., Psychologist III
James Brown, MSW, Psych. Social Wkr. II
Janean Redding, Mental Health Wkr. I
Laurel Hanson, Secretary III (part-time)

Counties Served:

Big Horn

RED LODGE

P.O. Box 482
Red Lodge, MT 59068
Telephone: 446-2500

Office Staff:

Lan Bauer, Ed.D., Psychologist V
Barbara Herbert, Secretary III (part-time)

Counties Served:

Carbon

ROUNDUP

Wall Building, Rm. #105
P.O. Box 265
Roundup, MT 59072
Telephone: 323-1142

Office Staff:

Ron Holland, M.Ed., Psychologist III
Dorothy Tragitt, Secretary III (part-time)

Counties Served:

Musselshell

HARLOWTON

304 Division St. Edison Bldg.
Harlowton, MT 59036
Telephone: 632-4508

Office Staff:

Gordon Saunders, M.A., Psychologist II
Paulette Aanrud, Secretary III (part-time)

Counties Served:

Wheatland

LEWISTOWN

211 South High, P.O. Box 44
Lewistown, MT 59457
Telephone: 538-3026

Office Staff:

Robert VanGriethuysen, Ed.D., Psychologist IV
Joan Maggio-Stockton, R.N., Psych. Nurse I
Mildred Gatz, Secretary III

Counties Served:

Fergus, Judith Basin and Petroleum

Non-Participating Counties: Golden Valley

South Central Montana (Region III) Mental Health Board

Clyde Cromwell, Chairman (Yellowstone)
820 Second Avenue
Laurel, MT 59044
Telephone: 698-4266

Mrs. Ruth Johnson (Sweet Grass)
Big Timber, Mt 59011
Telephone: 932-2304

Larry Vincent (Wheatland)
Box 241
Harlowton, MT 59036
Telephone: 632-5883

----- (Musselshell) - temporarily unnamed
Roundup, MT 59072
Telephone:

John Leuthold (Stillwater)
Molt, MT 59057
Telephone: 669-2544

Genevieve Dyche (Big Horn)
622 North Cody
Hardin, MT 59037
Telephone: 665-1906 (wk.)

Otto Jensen (Fergus)
County Commissioner
County Courthouse
Lewistown, MT 59457
Telephone: 538-5119

Art Klind (Judith Basin)
Hobson, MT 59452
Telephone: 738-2372

Ms. Lorraine Bauer (Petroleum) - Acting?
Petroleum County Manager
Petroleum County Courthouse
Winnett, MT 59087
Telephone: 429-4555

Carbon County Representative - Temporarily unnamed

Board members not yet designated from:
------Golden Valley County (non-participating)

SOUTHWEST MONTANA (REGION IV) MENTAL HEALTH CENTER

Administrative Office:
225 South Idaho Street
Butte, MT 59701
Telephone: 723-5489

Counties Served:
Park, Broadwater, Lewis & Clark, Silver Bow, Deer Lodge, Jefferson (south end)

Office Staff:
Cleo Butler, Community Mental Health Nurse
Barbara Sene, R.N., Community Mental Health Nurse
Joanne Soyland, Mental Health Worker III
Dollye Emerson, Secretary
Phyllis Burns, Secretary
Francine Larson, M.D., Psychiatrist (THURSDAY ONLY)

Satellite Offices:

HELENA
324 Fuller Avenue
Helena, MT 59601
Telephone: 442-0640

Counties Served:
Lewis & Clark, Broadwater, Jefferson (northern part)

Office Staff:
Joe Harrington, Administrative Director
James Foley, Administrative Officer
Mary Chronister, Clinical Psychologist
Robert Bateen, Clinical Psychologist
Iris Basta, Business Manager
Rosalie Walsh, Secretary
Renee Davis, Secretary-Receptionist
Francine Larson, Psychiatrist

LIVINGSTON
Box 119
Park County Courthouse
Livingston, MT 59047
Telephone: 222-3332

Counties Served:
Park, Meagher, Yellowstone Park

Office Staff:
Duane Haidle, M.ED., ED.D., Guidance & Couns. Psychologist
Fran Roberts, Social Worker
Irene Hedrick, Secretary

ANACONDA
Community Hospital Building
6th and Oak
Anaconda, MT 59711
Telephone: 563-5261, Ext. 76

Counties Served:
Deer Lodge

Office Staff:
Ben Peters, Psychologist
Lorene Frigaard, Secretary

DILLON
Barrett Memorial Hospital
Dillon, MT 59725
Telephone: 683-2324

Office Staff:
J. Bailey Molineaux, Clinical Psychologist

Southwest Montana (Region IV) Mental Health Board

Ed DeGeorge, Chairman (Silver Bow)
County Commissioners Office
Courthouse
Butte, MT 59701
Telephone: 792-1427

Art Woods, Secretary-Treasurer (Lewis & Clark)
County Commissioners Office
Courthouse
Helena, MT 59601
Telephone: 442-6737

Fred Meshenko (Deer Lodge)
County Commissioners Office
Anaconda, MT 59711
Telephone: 563-2610

Mrs. Pat Miller (Beaverhead)
Rural Rte. 1, Box 60
Dillon, MT 59725
Telephone:

James Sanddal (Jefferson)
Basin, MT 59631
Telephone: 225-9979
225-3332 (Courthouse)

James Plummer (Broadwater)
Toston, MT 59643
Telephone: 266-3443

Ray Shorthill (Park)
Park County Commissioners Office
Livingston, MT 59047
Telephone: 222-0450

Non-participating Counties

Board Members not yet designated from:

------Madison County
------Gallatin County
------Meagher County
------Powell County
------Granite County

WESTERN MONTANA (REGION V) MENTAL HEALTH CENTER

Administrative Office: Fort Missoula
Missoula, MT 59801
Telephone: 543-5177 (Hotline 125-5021)

Counties Served: Missoula

Office Staff:
G. Clark Anderson, Administrative Director
Mrs. Jane Closson, Administrative Assistant
Richard Ball, Ph.D., Psychologist
Joyce Gale, Ph.D., Psychologist
Mark Vincent, Psychologist
Nora Lou Fairley, Psychiatrist
James Scriver, Psychiatric Social Worker
David Washburn, Psychiatric Social Worker
Pam Goss, Mental Health Worker
Cheryl Bauer, Mental Health Worker
Linda Krieg, Secretary
Linda Calbrick, Clerk Typist
Rosalie Petersen, Clerk Typist

Satellite Offices:

KALISPELL
704 South Main Street
Kalispell, MT 59901
Telephone: 755-6262 (Hotline 136-27)

Counties Served: Flathead

Office Staff:
Herman Androes, Clinical Psychologist
Alan Quint, Psychiatrist
Willow Helton, Psychologist
Abe Swartz, Psychiatric Social Worker
Bernadette Dennison, Clerk Typist
Maureen Niltzing, Clerk Typist

RONAN
Drawer E
Ronan, MT 59864
Telephone: 676-8500

Counties Served: Lake

Office Staff:
Gordon Gerrish, Ph.D., Psychologist
John Schritz, Jr., Business Manager
Nancy Peterson, Clerk Typist

LIBBY
321 Mineral Avenue
Libby, MT 59923
Telephone: 293-6513

Counties Served: Lincoln

Office Staff:
Donald Snyder, Psychologist
Mary Picco, Clerk Typist

Western Montana (Region V) Mental Health Center - Satellite Offices
(continued)

THOMPSON FALLS
Box 562
Thompson Falls, MT 59873
Telephone: 827-3641

Counties Served: Sanders

Office Staff: William H. Harris, Psychologist
Sandra Margelin, Secretary

HAMILTON
186 South Third Street
Hamilton, MT 59840
Telephone: 363-1051

Counties Served: Ravalli

Office Staff: Frank Erickson, Psychiatric Social Worker
Erma Jorgenson, Clerk Typist

Western Montana (Region V) Mental Health Board

Bill Burley
Lake County Commissioner's Office
Polson, MT 59860
Telephone: 883-4361 (Office)
676-2138 (Home)

Jim Morey, President
County Commissioner's Office
Libby, MT 59923
Telephone: 293-5442

Dick Ostergren
Missoula County Commissioner's Office
Missoula, MT 59801
Telephone: 543-5234

Joe DeLong
County Commissioner's Office
Kalispell, MT 59901
Telephone: 752-4293

Ed Spannuth
County Commissioner's Office
Hamilton, MT 59840
Telephone: 363-4790

Hank Gill
County Commissioner's Office
Thompson Falls, MT 59873
Telephone: 827-3491

Non-Participating Counties

Duane Moeller (Mineral)
Saltese, MT 59867

MONTANA STATE PLAN FY 76

CASCADE COUNTY ADVISORY BOARD

Mrs. Helen Alexander
1026 Durango
Great Falls, MT 59404

Mrs. Jane Baker
1216 4th Avenue North
Great Falls, MT 59401

Mr. James D. Bergene
511 29th Avenue N.W.
Great Falls, MT 59404

Mr. W.H. Bertsche
1917 4th Avenue North
Great Falls, MT 59401

Rev. Olaf Borge
136 18th Avenue N.W.
Great Falls, MT 59404

Mr. John Breeden
506 29th Avenue N.E.
Great Falls, MT 59401

Judge William Coder
(Ex Officio)
City Police Judge
P.O. Box 1588
Great Falls, MT 59403

Mr. Russel Conklin
2500 4th Avenue South
Great Falls, MT 59405

Samuel Dachs, M.D.
Pathology Department
Deaconess Hospital
Great Falls, MT 59405

Ms. Ginny Dahinden
1801 10th Avenue South, #5
Great Falls, MT 59401

Senator Michael Greely
Strain Building
Great Falls, MT 59401

Mrs. Laulette Hansen
Social and Rehabilitation Services
1818 10th Avenue South
Great Falls, MT 59405

Mrs. Margaret Hilley
2725 Ivy Drive
Great Falls, MT 59401

Mrs. Donna Holland
321 8th Avenue South
Great Falls, MT 59405

Mrs. Joan-Nell MacFadden (Chairman)
2620 4th Avenue South
Great Falls, MT 59405

Mrs. Kay Myers
Northwestern Bank
213rd Street North
Great Falls, MT 59401

Mr. Charles R. Robbin
1900 5th Street N.W.
Great Falls, MT 59404

Lawrence Fasbender, County
Commissioner
Cascade County Courthouse
Great Falls, MT 59401

Lt. Col. Charles Signorina
Hospital Commander
Base Hospital
Malmstrom AFB, MT 59402

Mrs. Dorothy Sowa
Montana Nurses Association
c/o Deaconess Hospital
Great Falls, MT 59405

Mrs. Minerva Trotchie
615 15th Street North
Great Falls, MT 59401

Neil E. Ugrin, Attorney
Strain Building
Great Falls, MT 59401

Mr. Vincent S. Werner
2308 2nd Avenue South
Great Falls, MT 59405

TOOLE COUNTY MENTAL HEALTH ADVISORY BOARD MEMBERS

Vearle D. Addy, Chairman 1112 1st Street South Shelby, MT	-	Comprehensive Health Planning
Lenny Atkinson Sunburst, MT 59482	-	High School Student
Gelena Berkram 948 Westwood Shelby, MT	-	Nurse
A.F. (Bud) Criner 730 North Benton Shelby, MT	-	Mountain Bell & Ambulance
Mariann Cunningham Sunburst, MT 59482	-	High School Student
Mary Kay Thompson P1O. Box 67 Shelby, MT	-	Toole County Welfare
Karen LaVender 315 11th Avenue North Shelby, MT	-	Housewife
Shelley Marra 200 W. Cascade Shelby, MT	-	Sheriff's Dispatcher
Dee Nesbo, Secretary Box 411 Shelby, MT	-	Housewife
John Nesbo Box 411 Shelby, MT	-	Toole County Commissioner
Duane Parlow, Vice-Chairman 222 East Teton Avenue Shelby	-	High School Counselor
Rev. Martin H. Philipsen 531 Main Street Shelby	-	Ministerial Assn.
Eileen Randall 205 11th Avenue South Shelby, MT	-	P.H. Nurse
Noel Robison P.O. Box 748 Shelby, MT	-	High School Student

TOOLE COUNTY MENTAL HEALTH ADVISORY BOARD MEMBERS (continued)

Dennis Roseleip Sunbrust, MT	-	High School Counselor
Kay Schrammeck Sunbrust, MT	-	High School Student
Paul Schrammeck Sunburst, MT	-	Supertintendent of Schools
Jacky Severson 350 O'Haire Blvd. Shelby, MT	-	AA Counselor
Lina Shearer 912 2nd So. Shelby	-	Probation Officer
Matt Shearer Youth Development Bureau 424 Main Street Shelby, MT	-	Youth Development Coordinator
Judy Swenson 215 11th Avenue North Shelby, MT	-	Housewife

MONTANA STATE PLAN FY 76

GLACIER COUNTY MENTAL HEALTH ADVISORY BOARD

Deloris Thompson (Mrs. Charles)
Chairman
Box 2294
Cut Bank, MT 59427

Floyd Ray
406 7th Avenue S.E.
Cut Bank, MT 59427

Darrell Smith
402 4th Street S.E.
Cut Bank, MT 59427

Doris Meagher (Mrs. Joe)
449 7th Avenue S.E.
Cut Bank, MT 59427

Esther Smith
720 4th Street S.E
Cut Bank, MT 59427

Bob Raemaeker
Box 1282
Cut Bank, MT 59427

Kathy Mock
305 4th Avenue S.E.
Cut Bank, MT 59427

Rev. Glenn Brodin
522 1st Street S.E.
Cut Bank, MT 59427

Jewell Wolf (Mrs. Robert)
326 5th Avenue S.E.
Cut Bank, MT 59427

Lois Nelson (Mrs. Harold)
704 3rd Street S.E.
Cut Bank, MT 59427

Billie Wallace (Mrs. John)
232 2nd Avenue S.E.
Cut Bank, MT 59427

Catherine Brown (Mrs. Clyde)
125 9th Avenue S.E.
Cut Bnak, MT 59427

James Baker
Box 55
East Glacier, MT 59434

Steve Barcus
Box 580
Browning, MT 59417

MONTANA STATE PLAN FY 76

HILL COUNTY ADVISORY COMMITTEE

Mrs. Louis Hagener, Chairman
612 17th Street
Havre, MT 59501

Mrs. Glen Springer
1029 Third Street
Havre, MT 59501

Miss Nancy Niebauer
302 9th Street
Havre, MT 59501

Mr. Dean McFadden
Inverness, Montana 59530

Mrs. John B. Kuhr
1609 Pine Drive
Havre, MT 59501

Ms. Kathryn Tureotte
1314 4th Street
Havre, MT 59501

Mr. H.S. Cooper
817 Fourth Avenue
Havre, MT 59501

Mr. Dallas Keck
1258 Wilson Avenue
Havre, MT 59501

MONTANA STATE PLAN FY 76

CHOTEAU MENTAL HEALTH CENTER ADVISORY BOARD

Robert Gormley
Superintendent of Schools
Choteau Public Schools
Choteau, MT 59422

Betty Swenson
Teton County Health Nurse
Teton County Courthouse
Choteau, MT 59422

Reverend Allen Adams
Choteau United Methodist Church
12 1st avenue NW
Choteau, MT 59422

Charles Averill
Choteau, Mt 59422

Mrs. John Park
Dutton, MT 59433

MONTANA STATE PLAN FY 76

WESTERN MONTANA REGIONAL COMMUNITY MENTAL HEALTH CENTER

County Advisory Committees Chairmen

Ravalli County:	Mr. Allen Steele c/o Teleprompter Hamilton, MT 59840
Missoula County:	Dr. John Means Psychology Department University of Montana Missoula, MT 59801
Lake County:	Mr. Bill Harvey Ronan High School Ronan, MT 59864
Flathead County:	Mr. Doug Smith, D.M.D. Highway 35 Bigfork, MT 59911
Sanders County:	Mr. Cliff Stephens Box 16 Paradise, MT 59856
Lincoln County:	Mrs. Thomas Fennessy 401 Louisiana Avenue Libby, MT 59923

MONTANA STATE PLAN FY 76

SOUTH CENTRAL MONTANA

REGIONAL MENTAL HEALTH CENTER

BOARD MEMBERS

Clyde A. Cromwell, Board Chairman
820 2nd Avenue
Laurel, MT 59044

Otto Jensen
County Commissioner
Fergus County
Lewistown, MT 59457

Mr. Art Klind
County Commissioner
Judith Basin County
Raynesford, MT 59469

John H. Leuthold
Molt, MT 59011

Reverend Larry Vinson (Also Chairman of Wheatland County Advisory Board)
Box 241
Harlowton, MT 59036

Rev. Robert Lamphere
First Methodist Church
Bridger, MT 59014

Mr. Robert Notton
507 3 West
Roundup, MT 59072

SATELLITE ADVISORY BOARDS

Carbon County Advisory Board (All white ethnic)

Rev. Ruben Wilbur - Chairman
Betty H. Petec
Neil Ruedesilli
Orville Zinnerman
Ann Hilderman
Ben Karas, M.D.
Wally Nordstrom
Tracy Davis
Martha Herlevi
Ed Warner
Charles Pinnick
County Commissioners as ex-officio members
Rev. Robert Lamphere

Stillwater County Advisory Board (All white ethnic)

David T. Beans - Acting Chairman
David Matovick
Chuck Davis
Juanita Stine
Harvey Glock
Albert Thompson
Rose Blenkner

Stillwater County Advisory Board (All white ethnic) - continued

Nancy Wright
Ann Myers
Mark Robinson
Lois Bink
Grace Leuthold
Robert Conover
Bonnie Owen
Agnes Nordahl
John Leuthold

Sweet Grass County Advisory Board

Eugene Nilson
Ruth Johnson
John Boe
Pat Henthorn
James Graham
Lois Williams
Karen Nitcey
Ray Esp
Conrad Fredricks
Michael Jenkins
Olivery Tanquary
Robert Hauck
Ed Argenbright
Mrs. Shirley Shilling
Pat Brownlee
Dorothea Huff
Alice Adams

Big Horn County Advisory Board

Mrs. Betty Spomer (Ind.)
Mrs. C. Dyche
Manuello Mesteth (Ind.)
Ellie King
Eugene Clark
Josephine Pretty Weasel (Ind.)
Luana Auker
Fabian Fehring
Dr. W. Anderson
Dr. Michael Downing
Robert Brown
John Besel
Ed Miller
Paul Martin
Connie Swedberg
John Lind

Musselshell County Advisory Board

Ron Holland
Don Belcher
Jack Ellis
Gene Pruitt
John Liggett
Ruth Amdor
Jim Helgeson
Roy and Chaterine Fairley
Nina Rogerson
Henry Howard
Tom Ask
Ralph Gildroy
Art Fregilson
Linda Carlee
Linda Goffena
Bob Jorgenson
Robert Notton

Fergus County Advisory Board

James Craig
Mrs. Helen Jackson
Senator Don Foster
Mrs. Ruth Sirakey
Boll Spoya
Patty Garlick (Ind.)
Joy Wicks
Kevin Spraulding
Nick Cerovski
Pat McGuire
County Commissioners as ex-officio

Wheatland County Advisory Board

Larry Vinson
Mrs. Glicko
Joe Fahn
Mrs. Lewis
Robyn Peake
Dwaine Meyers
Donna Burdren
C.A. Buckley
Lary Clifford
Jimmy Zigweid
Ron Miller
Julian Pessein
Don Bain
Bob Nish
Dale Bennett
Donn Conley

MONTANA STATE PLAN FY 76

PARK COUNTY MENTAL HEALTH ADVISORY BOARD

Elizabeth Lahren, Chairman
109 South C.
Livingston, MT 59047

Julia Regele
629 N. 3rd
Livingston, MT

Reverend Sutterlin
210 E. Lewis
Livingston, MT

Nancy Gilbert
Clyde Park, MT 59018

Joanne Wacker
117½ N. 7th
Livingston, MT

Jo Yarkley
202 South 8th
Livingston, MT

Judy Schultz
423 N. Yellowstone
Livingston, MT

Dr. Bray
524 W. Lewis
Livingston, MT

Ray Shorthill
12 Big Horn Drive
Livingston, MT

Mike Fleming
Livingston, MT

Bill Harris
South of Livingston, MT

Dr. Notebocm
419 N. 5th
Livingston, MT

Irene Hedrick - Secretary
424 W. Clark
Livingston, MT

*Bill Warfield
S. of Livingston

*John Gilbert
Clyde Park, MT

*Dan Blakeslee
Pray, MT

*Ken Spalding
616 Meadowlark Lane
Livingston

*Ex-officio

MONTANA STATE PLAN FY 76

SILVER BOW COUNTY MENTAL HEALTH ADVISORY BOARD MEMBERS

Judge Arnold H. Olsen
Silver Bow County Courthouse
Butte, MT 59701

Ms. Val Webster
103 E. Broadway
Butte, MT

Gary Gorsh
2201 Cottonwood Street
Butte, MT

Al Dirksen
740 S. Main
Butte, MT 59701

Jean Weraja
424 Indian Avenue
Butte, MT

Tom Frankovich
43 E. Broadway
Butte, MT

DEER LODGE COUNTY MENTAL HEALTH ADVISORY BOARD MEMBERS

Jack Boley, Chairman
c/o KANA Radio Station
105 Main Street
Anaconda, MT 59711

Fred Meshenko
Deer Lodge County Courthouse
Anaconda, MT 59711

Anne Needham
821 W. 5th Street
Anaconda, MT 59711

Sally Flynn
604 Locust Street
Anaconda, MT 59711

Val Galle
Deer Lodge County Courthouse
Anaconda, MT 59711

Diane McCorkle
200 Main Street
Anaconda, MT 59711

Dick Rosenleaf
Warm Springs, MT 59756

MONTANA STATE PLAN FY 76

LEWIS AND CLARK COUNTY MENTAL HEALTH ADVISORY BOARD MEMBERS

Carlene Armstrong
454 Lawrence
Helena, MT 59601

Alice Armstrong
2919 Country Club Avenue
Helena, MT

Jeane V. Richardson
1013 Dearborn
Helena, MT

Jo Loos
Helena, MT

Bertha Heinemeyer
415 S. Fee Street
Helena, MT 59601

Bob McKinnon
2200 North Benton
Helena, MT

Steve Benowitz
Boulder, MT 59632

Bernardine Wallace
Helena, MT

Duane Moulding
Helena, MT

BEAVERHEAD COUNTY ADVISORY COMMITTEE

Mrs. Marvin (Patti) Miller
RR1, Box 60
Dillon, MT 59725

Tom McGovern
702 East Bannack
Dillon, MT

Tom Delaney
310 South Nevada
Dillon, MT

Blake Huntley
922 East Morse
Dillon, MT 59725

Ted Hazelbaker
404 South Washington
Dillon, MT

Keith Lokensgard - Chairman
24 South Pacific
Dillon, MT

MONTANA STATE PLAN FY 76

ADVISORY BOARD
Conrad Mental Health

Mr. and Mrs. Gordon Matheson
609 Sunset Blvd.
Conrad, MT 59425

Mr. and Mrs. Ivan Lenz
Brady, MT 59416

Mr. and Mrs. John Lusty
719 South Michigan
Conrad, MT

Mr. and Mrs. Robert Peters
412 South Illinois
Conrad, MT 59425

Mr. and Mrs. Robert R. Emrick
NE of Conrad
Conrad, MT 59425

Mrs. Marge Matheson
Chairman

Rev. and Mrs. Richard Omlend
1 South Maryland
Conrad, MT

Mr. and Mrs. Robert Norsby
Valier, MT 59486

MONTANA STATE PLAN FY 76
AGREEMENT

THIS AGREEMENT, made and entered into this _____ day of _____, 19____, between the MONTANA DEPARTMENT OF INSTITUTIONS, ADAPTIVE SERVICES DIVISION, ADDICTIVE DISEASES BUREAU, hereinafter called "STATE", and the GOVERNING BOARD OF THE NORTH CENTRAL MONTANA REGIONAL MENTAL HEALTH CENTER, hereinafter called "BOARD".

WITNESSETH:

Whereas, the State of Montana, Department of Institutions has received approval of the FY 1974-75 State Plan for Alcohol and Alcohol Abuse and sufficient funding to implement the Plan, and,

Whereas, the Director of the Department of Institutions and the Administrator of the Adaptive Services Division desire to contract with a corporation that provides service to the following Montana counties: Blaine, Cascade, Chouteau, Glacier, Hill, Liberty, Pondera, Teton and Toole, also known as Montana Mental Health Region II, and

Whereas, the North Central Montana Regional Mental Health Governing Board is agreeable to and desirous of expanding their current scope to coordinate with existing alcohol services and sub contract to Region II its share of FY 1974-75 formula money to existing approved alcohol programs to implement the Uniform Detoxification Act.

Now, therefore, it is agreed that the Governing Board shall render services to a Mental Health Region on behalf of the State in consideration of the terms, conditions, covenants, and performance as set forth in this agreement and its attached exhibits which are incorporated and made part of this agreement.

The parties hereto agree as follows:

ARTICLE I.

That the Board is to be a contracting agency with the State; in

this regard the Board shall have such authority and is to perform such duties as a contracting agency which include carrying out certain administrative directives issued by the State that are not in violation of the terms of this contract and those directives inherent in the federal formula grant. In addition those services to be performed as a contracting agency under this contract by the Board are only those such services as are enumerated in Article V. of this agreement.

Any disagreements as to the responsibility of the Board to State or as to the authority of the Board vis-a-vis the authority of the State under this contract shall be resolved according to the terms of this contract. Resolution of any such disagreements shall be effected pursuant to the renegotioation and modification clause in Article IX of this agreement.

ARTICLE II.

It is further agreed that the Board must subcontract any services which are materially involved with alcohol treatment related services to be provided under this contract. All subcontracts for alcohol services must be submitted to the State for prior approval.

ARTICLE III.

It is further agreed that the Board must establish an adequate accounting system for controlling and identifying all agency activities directly related to this contract. Monthly financial reports must be published and shall be submitted to the Addictive Diseases Bureau, 1539 11th Ave., Helena, Montana 59601, which reflect the status of the Board, at a minimum the monthly report must show monthly costs incurred and rendered for reimbursement received, outstanding reimbursements, and total costs year-to-date.

It is understood and agreed to that the board may sub-contract for accounting services that it deems necessary and advantageous. However,

the State does not agree to accept any regulations or policy which generates from any such sub-contracting which are contradictory to or in violation of the terms of this contract.

In the event that disagreement should arise between the Board and its above sub-contractees, the State specifically disclaims any liability to such sub-contractees and the Board agrees to hold the State free and clear of any such liability.

The Board agrees to make available to the State or their designated auditor all financial records for contract and program audit purposes. The State agrees to pay for all required audit expenses.

ARTICLE IV.

It is further agreed that the Board will maintain recordkeeping that presents a current and continuous account of the Regional Addictive Diseases Resource Development Specialist (RADRDS) responsibility in providing treatment services; that is, diagnostic statements which clearly indicate the treatment staff's current evaluation of the problem and treatment goals and necessary material for evaluation of staff performance by the Board or State. These records will be available to the Adaptive Services, Administrator, or his designee, during regular working hours of operation. The State shall abide by the Federal, HEW "Confidentiality of Alcohol and Drug Abuse Patient Records," provisions at all times.

ARTICLE V.

Services

The Board will employ one staff member who will work in Region II to develop comprehensive alcohol services in those counties where services do not now exist or to expand services in those counties where limited services exist. The Board will sub-contract to an existing alcohol program to provide training to all service provider agencies in Mental

Health Region II on the implementation of the Uniform Detoxification Act. The Board, through the above mentioned staff member, will pay for medical and non-medical detoxification expenses when the recepient and/or no other agency can pay for such services. Detoxification funds of $10,000.00 will be allocated proportionally to each county based on total population of the Mental Health Region II and the population of each individual county in the Region. In no event will any county receive less than a minimum of Four Hundred dollars ($400.00). Under no condition is the North Central Montana Regional Mental Health Center liable for any amount in excess of $10,000.00 detoxification liability for the seventeen counties. If there is an approved alcohol program serving a county, or counties, in the Region, detoxification funds for that county must be sub-contracted to the approved alcohol program for expenditure for direct services provided alcohol clients.

The State will, from time to time, require the attendance of the Board staff member at various meetings throughout the State and the Board is agreeable to permitting the staff member, as part of his regular duties, to attend these meetings. The Board staff member will be required to submit, to the State, a monthly report of activities, alcohol and other substance abuse needs assessment periodically, and a comprehensive regional plan for meeting identified needs in January, 1977.

ARTICLE VI.

Terms

This contract is to take effect on the 1st day of June, 1976, and is to continue in force until April 30, 1977, subject, however, to termination which may be effected by either party upon giving of written notice to the other party thirty (30) days in advance of the date of termination.

This contract shall, in any case, terminate at such time as

Federal FY'74-75 Alcohol Formula Funding may be revoked or otherwise terminated.

It is understood between the parties that this contract may be continued subject to any renegotiations as may be necessary and subject to the concurrence of both parties on any renegotiated terms of the existing contract.

At such time as this contract terminates, the State agrees to pay for any expenditures incurred by the Board pursuant to the terms of this contract on or before the date of termination.

ARTICLE VII.

Compensation

The State will pay the Board a maximum of $25,000.00 to pay the salary and all fringe benefits of the staff member, necessary mileage and per diem at the prevailing State rate, and all other staff ancilliary services, i.e. office space, telephone, consumable office supplies, limited secretarial support, and necessary bookkeeping and accounting services.

The State will pay the Board $15,000.00 to be utilized to implement the Uniform Detoxification Act as follows:

1) $5,000.00 to be utilized for education and training needed to implement the Uniform Detoxification Act.

2) $10,000.00 to be utilized for care provided by medical facilities implementing the Uniform Detoxification Act in Montana Mental Health Region II. Payment for services received by alcoholics will be made only after documentation and verification of the services is made by the Regional Addictive Diseases Resource Development Specialist assigned to the Region.

All payments will be made by the State to the Board on a reimbursement basis of actual expenses incurred.

Training

The Board staff member will participate in and contribute to in-service training programs provided by and through the State designated staff members.

ARTICLE IX.

Renegotiation and Modification

It is further agreed that this contract or any part hereof is subject to renegotiation at any time; that such renegotiation may be initiate by either party giving notice in writing to the other party as to the item (s) to be renegotiated.

However, no modification of this agreement shall be binding upon either of the parties hereto unless such modification shall be in writing and duly accepted and approved in writing by both parties.

ARTICLE X.

Personnel Manual

The Board has provided assurance to the State that personnel management of the Regional Addictive Diseases Resource Development Specialist shall be maintained in accordance with legal and proper maintenance standards by virtue of the development of a personnel policies and procedures manual which is set out in Exhibit "A" to this contract and incorporated herein by this reference. The manual may be revised from time to time and maintained current by the Board. A copy of all revisions to the personnel manual shall be mailed to the State, Addictive Diseases Bureau, Chief, 1539 11th Ave., Helena, Montana 59601.

ARTICLE XI.

Board

The Board shall send minutes of the corporate board meetings to the Chief, Addictive Diseases Bureau, 1539 11th Ave., Helena, Montana 59601.

IN WITNESS WHEREOF, the parties hereto have set their hands this _____ day of _____ 19____.

Dr. Robert H. Mattson, Director Department of Institutions	Witness
Dr. Larry Carlson, Administrator Adaptive Services Division	Witness
President Governing Board North Central Montana Regional Mental Health Center	Witness
Secretary Governing Board North Central Montana Regional Mental Health Center	Witness

SECTION 6

6.1 ALLOCATION OF STATE ALCOHOLISM FUNDS FY 76

6.2 ALLOCATION OF FY 75 ALCOHOL TAX BY DEPARTMENT OF REVENUE

6.3 PROPOSED ALLOCATION OF FY 77 STATE FUNDS FOR ALCOHOLISM SERVICES

MONTANA STATE PLAN FY 76

CURRENT ALCOHOLISM CONTRACTS

AS OF 3-5-76

FISCAL YEAR 76 GENERAL FUND - CONTRACTS

WITH LOCAL PROGRAMS

Action for Eastern Montana	$ 240.66	Staff Training
City/County Health Dept-Great Falls	148,529.10	Client Service
Custer County	9,500.00	Client Service
Rimrock Guidance - Billings	42,646.00	Client Service
Council of Counties - Dist I	40,829.00	Client Service
Council of Counties - Dist II	28,200.00	Client Service
Rosebud County	4,636.48	Client Service
N.W. Mont Alc Program - Kalispell	42,411.00	Client Service
Hill-Top Recovery - Havre	54,700.00	Client Service
ARA - Helena	60,609.77	Client Service
City/County - Great Falls	755.00	Staff Training
Colstrip Youth Project	9,750.00	Client Service
Frontier - Dillon	30,000.00	Client Service
Deer Lodge County	15,795.00	Client Service
	$488,602.01	

The process for the allocation of FY 77 State General fund alcoholism monies began in February of 1976. All of the known programs were notified by letter that application kits were available on request. A public announcement was also printed in the five major state newspapers, indicating that funds were available. (See attached copy of news clippings.)

Those programs or agencies requesting application kits were advised that March 30, 1976 was the deadline for receipt of completed applications. The programs were also notified that technical assistance was available, on request, from the staff of the Bureau of Addictive Diseases. The staff of the Bureau participated in several training sessions covering the aspects of the application such as budget development, refinement of goals and objectives and techniques for involving other providers of service to the alcoholism clients. These training sessions were "In House" and were meant to prepare the staff of the Bureau for the rendering of technical assistance. A staff person was assigned to each program or agency requesting application material. The staff person contacted the program and inquired as to whether they desired technical assistance. Most of the programs did request this staff assistance and received ample help with the mechanics of the application. The Bureau staff used caution so as not to influence the nature and scope of the goals and objectives.

The applications were received, recorded, and given a preliminary review by the staff to insure completeness and accuracy of detail, including budget computations. The programs were notified of

MONTANA STATE PLAN FY 76

STATE ALCOHOL TAX PAID TO COUNTIES

Beaverhead	17,158.45	McCone	3,698.81
Big Horn	13,844.86	Meagher	4,007.94
Blaine	11,548.66	Mineral	8,540.80
Broadwater	4,508.04	Missoula	131,526.93
Carbon	12,339.09	Musselshell	7,396.88
Carter	2,005.12	Park	21,598.45
Cascade	162,295.24	Petroleum	674.16
Chouteau	9,762.68	Phillips	9,693.06
Custer	26,417.83	Pondera	10,927.72
Daniels	4,940.95	Powder River	3,036.96
Dawson	16,643.62	Powell	11,516.90
Deer Lodge	20,979.06	Prairie	2,075.42
Fallon	6,407.44	Ravalli	24,384.43
Fergus	19,248.77	Richland	15,759.76
Flathead	78,376.17	Roosevelt	21,437.38
Gallatin	70,215.15	Rosebud	18,048.95
Garfield	2,263.64	Sanders	14,680.14
Glacier	28,179.19	Sheridan	12,159.06
Golden Valley	915.68	Silver Bow	99,310.77
Granite	5,583.18	Stillwater	7,836.14
Hill	32,779.65	Sweetgrass	6,809.86
Jefferson	7,621.70	Teton	8,403.43
Judith Basin	3,688.95	Toole	12,325.06
Lake	27,394.17	Treasure	1,500.89
Lewis & Clark	84,323.99	Valley	18,725.64
Liberty	3,337.34	Wheatland	5,792.92
Lincoln	26,273.36	Wibaux	2,424.72
Madison	9,945.67	Yellowstone	187,367.47

incomplete sections and errors in computation and asked to submit additional material that would be available for the final review.

Each application received an independent review by three staff persons and then the three met in conference and heard an overview and summary report by the staff person who provided technical assistance for each application. The three staff persons, without the technical assistance person, made a final staff recommendation. The final staff recommendation for each application was recorded on a master list and sent to the Advisory Council members along with the applications.

The review process by the Advisory Council was structured in a similar manner. Each application was reviewed by three Council members on an independent basis and then the three met in conference and heard an overview and summary report by the staff person who had provided technical assistance to the program. The three Advisory Council members then made a recommendation that was recorded for each application.

The final review phase consisted of the full Advisory Council and all of the Bureau staff reviewing all of the staff recommendations and all of the Council recommendations. The Advisory Council then made its final recommendation which is recorded in the official minutes of that meeting and included in Section 4.3.

The Advisory Council used a ranking for funding that consisted of three priorities:

1. Priority 1 - existing programs that had been previously funded with state general fund monies.

2. Priority 2 - new programs proposing to provide or offer comprehensive alcoholism services.

3. Priority 3 - special interest programs proposing to offer service to a limited group of clients or provide a narrow scope of service.

The Advisory Council and the Bureau staff reviewed and made recommendations on twenty-five (25) applications for FY 77 state general fund monies. The total dollar amount requested was $1,099,000.00 which far exceeded the actual amount available.

The amounts requested and the actual amounts awarded are as follows:

PROGRAM	REQUESTED	AWARDED
Rimrock Guidance Foundation	$120,178.00	$102,237.00
Billings Deaconess Hospital	50,000.00	45,000.00
Deer Lodge County	8,686.34	8,000.00
District II Council of Counties	30,000.00	30,000.00
Billings Indian Center	33,532.00	-0-
Libby	10,200.00	9,894.00
Northern Cheyenne	24,584.29	-0-
Crow Agency	26,719.93	10,000.00
Missoula City/County Health Dept.	27,950.65	26,832.65
District I Council of Counties	58,906.69	54,783.69
Employee Assistance - Missoula	20,065.00	9,099.96
Rosebud County	9,633.33	9,633.33
Hill-Top Recovery - Havre	87,250.00	78,525.00
Fort Peck, Poplar	19,913.07	10,019.34
Fort Belknap, Harlem	26,400.00	6,000.00

MONTANA STATE PLAN FY 76

PROGRAM	REQUESTED	AWARDED
N.W. Montana Alcchol - Kalispell	$ 52,000.00	$ 50,569.00
Flathead Reservation, Ronan	15,180.00	14,725.00
Colstrip Youth Project	13,110.00	13,110.00
Denny Driscoll Boys' Home, Butte	99,000.00	-0-
Alcohol Rehabilitation, Helena	70,000.00	64,400.00
Shelby Middle School	2,008.67	-0-
Powell County	14,000.00	13,580.00
Blackfeet Reservation	34,000.00	10,000.00
City/County Health - Great Falls	201,361.00	153,000.00

Proposed Alcohol Funding (all priorities) per Mental Health Region:

I. $129,248.36
II. $247,525.00
III. $147,237.00
IV. $135,980.00 (includes $50,000 Denny Driscoll Home)
V. $111,120.61

Costs for the Projects:

Priority I. $705,110.97 ($8,000.00 of this amount will not be contracted until January 1, 1977 - Deer Lodge County).

Priority II. $26,000.00 ($731,110.97) Programs in this category are: Crow, Blackfeet, Fort Belknap.

Priority III. $50,000.00 ($781,110.97) the only approved amount in this priority is to fund the Denny Driscoll Boys' Home.

Sources of ADB funding to meet the proposed costs:

State general fund FY 77	$449,000	
State general fund FY 76	40,000	(estimated carryover)
Federal formula FY 76	156,250	
Title XX	123,000	(estimated)
	$768,250	

SECTION 7

7.1 APPLICATION USED IN REQUESTING STATE FUNDS

7.2 FORMS USED FOR STAFF REVIEW OF APPLICATIONS

7.3 CRITERIA FOR APPROVAL OF SERVICE PROVIDERS

7.4 DEFINITIONS OF SERVICE COMPONENTS

State of Montana

Department of Institutions

GOVERNOR
THOMAS L. JUDGE

DIRECTOR
ROBERT H. MATTSON

BOARD MEMBERS
ZELLA A. JACOBSON GREAT FALLS
ELDON E. KUHNS, BILLINGS
WILLIS M. MCKEON, MALTA
ROBERT J. PALLO, KALISPELL
JOHN W. STRIZICH, M.D., HELENA

Helena, 59601

MONTANA STATE PLAN FY 76

To: Alcohol Programs

SUBJECT: Alcohol Funding Application

This packet contains the necessary forms, guidelines and instructions for completing the enclosed application to request Department of Institutions, Addictive Diseases Bureau alcohol funds.

The completed application should represent a merger of your thinking and planning. It should relate the services to be delivered to alcoholics and alochol abusers with the necessary budget to implement those services. Your application must be complete within itself, do not refer to other items we may or may not have on file.

Each portion of the application is important, as each provides you with the opportunity to define segments of your total service delivery system. This application has been rewritten and simplified for your convenience in applying for funds.

Technical assistance is readily available for you in completing this comprehensive application form. If you desire staff to provide on-site assistance with your application, please call Paul Babbitt or Mike Murray at 449-2827 for scheduling. The Addictive Diseases Bureau <u>will not</u> write your application or set your program's goals or establish your

objectives for you. We can help you process your plans for working with alcoholics and the problem of alcoholism.

The completed application must be received by the Department of Institutions, Addictive Diseases Bureau, not later than March 30, 1976, to receive review and consideration for funding. Your completed application form will receive a competitive review by both staff and Advisory Council Members. Once a member of this staff has provided assistance to your agency, they will automatically be disqualified from any in-office or Advisory council review or recommendation of your grant application or funding.

DEPARTMENT OF INSTITUTIONS
Addictive Disease Bureau
Application for Alcohol Service Funds

1. APPLICANT AGENCY

Name: _____

Address: _____

Telephone: _____

2. PROJECT DIRECTOR

Name: _____

Address: _____

Telephone: _____

3. OFFICIAL AUTHORIZED TO SIGN
(Chairman of the Board, etc.)

Name: _____

Title: _____

Address: _____

Telephone: _____

4. PROJECT TITLE

_____

_____

5. FINANCIAL MANAGER

Name: _____

Address: _____

Telephone: _____

6. TYPE OF APPLICANT

State Government Agency: _____

Local Government Agency: _____

Private Tax Exempt __ IRS No. _____

Private Agency: _____

7. LIST COUNTIES TO BE SERVED BY THIS PROJECT

_____

_____

_____

_____

Date Application Received: _____

Application Number: _____

Program Approved: Yes ____ No ____

Approved For:

Emergency Medical	Yes ___	No ___
Emergency Non Med	Yes ___	No ___
Intermediate Care	Yes ___	No ___
In Patient Treatment	Yes ___	No ___
Out Patient	Yes ___	No ___
Follow Up Care	Yes ___	No ___
Alcohol Education	Yes ___	No ___

Continuation Funding _____

New Funding _____

THIS BOX FOR DEPARTMENT USE ONLY

8. CONTRACT DURATION

From: _____ To: _____

Total Length in Months: _____

9. TOTAL AMOUNT OF THIS REQUEST FROM DEPARTMENT OF INSTITUTIONS $_____

Local Program Match: _____

Total Contract Costs: _____
(Total State & Match)

Total Alcohol Project Costs: _____

List other sources of funding for the period of time described above (eg. S.R.S. Voc. Rehab, Title XX)

_____

_____

_____

_____

_____

_____

_____

_____

_____

10. Assurances:

A. It is understood and agreed by the applicant that any funds received as a result of this application shall be subject to the conditions, regulations, rules and policies issued by the Department of Institutions for the administration of these State Gereral Fund monies. This includes, but is not limited to:

1) That funds awarded are to be expended only for the purposes and activities covered by the applicant's approved plan and budget;

2) That these funds may be terminated in whole or in part by the Montana Department of Institutions or its designee with thirty (30) days notice;

3) That appropriate fiscal records and accounts will be maintained and made available for audit by the Legislative Auditor of the State of Montana (Section 79-2310, R.C.M. 1947) and/or other auditors appointed by the Department of Institutions, and that these records will be so maintained for a period of five years;

4) It is required that all contractees will maintain record-keeping that presents a current and continuous account of the efforts in providing funded services necessary for evaluation of staff performance by supervisory staff. All records must be maintained in a manner consistent with established Addictive Diseases Bureau policy and procedures. These records will be available to the Addictive Diseases Bureau Director or his designee consistent with the Federal Law (P.L. 93-282 - see Federal Register July 1, 1975, excerpts enclosed).

5) That all data, information and/or reporting systems required by the Department of Institutions will be provided on the schedule and in the format prescribed by the Department.

I certify, upon receipt of these requested funds, to adhere to the preceding conditions and further certify that all information contained in this application is true and complete to the best of my knowledge.

Signed _____
Official Authorized to Sign Application

Title _____

Address _____

Telephone _____

Date _____

SUMMARY BUDGET FOR CONTRACT PERIOD From (Through	TOTAL AMOUNT REQUIRED	SOURCE OF FUNDS APPLICANT AND OTHER	SOURCE OF FUNDS REQUESTED FROM ADB	FOR ADB USE ONLY
1. Personal Services				
2. Contracted Services				
3. Supplies & Materials				
4. Communications				
5. Travel				
6. Rent				
7. Utilities				
8. Repairs & Maintenance				
9. Equipment				
10. Other				
11. TOTAL COSTS				

12. SOURCE OF FUNDS - Applicant & Other	(F)(S)(L)(O)	MATCHING REQUIREMENTS	OTHER	
A. Source of Applicant Funding (Identify each source separately)				
B. Payment for Services Provided by Client (Fees, collection etc.)				
(1) Title XIX (Medicaid)				
(2) Other				
TOTAL				

INSTRUCTIONS TO APPLICANT
DETAILED BUDGET

This budget should provide a complete picture of the financial requirements of the project. Enter the total amount required for each item in Column 4, show the expected source of funding for the amount in Columns 5 and 6.

1. Personal Services

Enter in Column 1 the annual (12 month) salary rate for each position which will be filled for all or any part of the year by an incumbent working on the project.

Enter in Column 2 the number of months the position will be filled by an incumbent working on the project.

Enter in Column 3 the percent of time or effort the incumbent will devote to the project during the number of months shown in Column 2.

Enter in Column 4 the total amount required, as computed from the information shown in Columns 1 thru 3. Use the following formula:

$$\text{Annual Salary (Col. 1)} \times \frac{\text{No. of Months (Col. 2)}}{12} \times \text{Percent of Effort (Col. 3)} = \text{Total Amount Required (Col. 4)}$$

EXAMPLES

Applicant				Project Identification No.		
Detailed Budget for this Period (Direct Costs Only)	ANNUAL SALARY RATE	NO. MOS. BUDG.	% TIME	TOTAL AMOUNT REQUIRED	SOURCE OF FUNDS: APPLICANT AND OTHER	SOURCE OF FUNDS: REQUESTED FROM ADB
	(1)	(2)	(3)	(4)	(5)	(6)
1. PERSONAL SERVICES						
Full-Time Employee of Institution working 60% time on project.						
John Doe	$24,000	12	60%	$14,400	$1,440	$12,960
Calculation	24,000 X	$\frac{12}{12}$ X	60%	= $14,400		
Summer Employee (3 months) to be paid $1000 a month. Will work on project 25% of time.						
Richard Roe	$12,000	3	25%	$ 750		$ 750
Calculation	12,000 X	$\frac{3}{12}$ X	25%	= $ 750		

DETAILED BUDGET FOR CONTRACT PERIOD	ANNUAL SALARY RATE	NO. MOS. BUDG.	% TIME	TOTAL AMOUNT REQUIRED	SOURCE OF FUNDS	
					APPLICANT AND OTHER	REQUESTED FROM ADB
	(1)	(2)	(3)	(4)	(5)	(6)
1. Personal Services						
A. Salaries						
B. Other Compensation & Hourly Wages						
C. Fringe						
CATEGORY TOTAL				$	$	$

DETAILED BUDGET FOR CONTRACT PERIOD (Continued)	TOTAL AMOUNT REQUESTED	SOURCE OF FUNDS	
		APPLICANT AND OTHER	REQUESTED FROM ADB
	(4)	(5)	(6)
2. Contracted Services			
CATEGORY TOTAL	$	$	$
3. Supplies & Materials			
CATEGORY TOTAL	$	$	$
4. Communications			
CATEGORY TOTAL	$	$	$

DETAILED BUDGET FOR CONTRACT PERIOD (Continued)	TOTAL AMOUNT REQUESTED	SOURCE OF FUNDS	
		APPLICANT AND OTHER	REQUESTED FROM ADB
	(4)	(5)	(6)
5. Travel			
CATEGORY TOTAL	$	$	$
6. Rent			
CATEGORY TOTAL	$	$	$
7. Utilities			
CATEGORY TOTAL	$	$	$

DETAILED BUDGET FOR CONTRACT PERIOD (Continued)	TOTAL AMOUNT REQUESTED	SOURCE OF FUNDS	
		APPLICANT AND OTHER	REQUESTED FROM ADB
	(4)	(5)	(6)
epairs & Maintenance			
CATEGORY TOTAL	$	$	$
9. Equipment			
CATEGORY TOTAL	$	$	$
10. Other			
CATEGORY TOTAL	$	$	$

BUDGET JUSTIFICATION

INSTRUCTIONS: Show justification for specific items or categories listed in the detailed budget for which the need is self-evident. Justifications should clearly indicate that the items being requested are essential to the achievement of the stated project objectives and the conduct of the proposed procedures.

PERFORMANCE SITE DATA

PERFORMANCE SITE(S) — The place where the project will be conducted.

SITE NO. _____ (Name) ADDRESS (Street Number, Street Name, City, County, State (or Country) REGION	SITE NO. _____ (Name) ADDRESS (Street Number, Street Name, City, County, State (or Country) REGION
SITE NO. _____ (Name) ADDRESS (Street Number, Street Name, City, County, State (or Country) REGION	SITE NO. _____ (Name) ADDRESS (Street Number, Street Name, City, County, State (or Country) REGION
SITE NO. _____ (Name) ADDR (Street Number, Street Name, City, County, State (or Country) REGION	SITE NO. _____ (Name) ADDRESS (Street Number, Street Name, City, County, State (or Country) REGION

Prepare a Cost Per Client Formula in the space alloted below. Enclose Fee Schedule if developed.

12. Describe all current applications or proposals for other funding, the sources and present status and how current and requested funds will be utilized.

13. Provide copy of certified audit completed within 12 months of application date.

14. Enclose letters or other documentation of necessary one-third cash match.

15. Document that applicant agency has, or applied for, at least $300,000 of liability insurance covering the total operation including the use or private vehicles and other vehicles for the transportation of clients.

16. The local program must define, in writing, its own policies pertaining to transportation of clients.

17. PROJECT PLAN AND SUPPORTING DATE

A detailed narrative description must be submitted on continuation pages, use any plain white paper 8½ x 11 inches.

Together with the project budget, it provides primary evidence for review of the soundness of the project, the care and planning that has gone into the formulation and the responsibility and qualifications of the applicant and others who will be involved.

A. Describe the applicant agency. Include:

1) A brief description of the agency's history. (200 words maximum.)

2) Describe the agency's various components and submit an organizational chart for the whole agency.

3) An explanation of the proposed project's relationships to the applicant agency.

B. The need for the proposed project must be confirmed.

1) Describe the physical area served.

2) Indicate the estimated number of alcohol abusing or at-risk individuals and their families who are potential consumers of the proposed services. (Cite the sources of these statistics.)

3) Discuss any ethnic or economic sub-populations for whom services are specifically tailored, and why not reached by the existing program and why special program needed.

4) State the number of target population clients that the project expects to serve over a 12 month period.

5) Describe the facilities to be used in the project, their locations, and the accessibility of these sites to consumers.

C. Present a concise statement of the project's philosophy of working with alcohol abusers and their families.

D. Clearly state the project's goals and objectives.

1) List the project's goals. Below each goal state the objectives that, combined, will lead to the accomplishment of that goal. (Goals should speak to the broad inter-personal, social, etc. problem areas addressed by the project. Objectives should state specific measurable steps to be taken in fulfilling each goal. When all the objectives have been met, the goal has been achieved.)

2) Each objective should include a specific time period for its accomplishment. A time-line should be included which illustrates anticipated progress.

3) Division of staff labor toward the achievement of each objective should be clearly shown.

E. Project evaluation should be undertaken to provide feedback on two levels:

1) At the administrative level, evaluation facilitates a clear understanding of developmental progress toward specified goals and objectives.

2) At the service level, evaluation indicates the effectiveness of services in fostering client improvement in total social functioning.

Proposals must include a detailed description of the qualitative and/or quantitative methods chosen to evaluate going organizational and service development. Data collection forms (intake and case record forms, client feedback forms, etc.) must be included in the application, and applicants must give assurance of the confidentiality of these data; i.e., access to and use of information will be restricted to appropriate project staff with exceptions only as stated in Federal Law (P.L. 93-282 - see Federal Register July 1, 1975, excerpts enclosed).

3) Specify policies and procedures to assure program coordination and continuity of client care within the proposed project following initial client contact or intake. A client flow chart must be provided which illustrates movement from one element or activity to another. (Client flow chart enclosed).

(In projects such as those with a strong coordinative and referral function it is important that the client not get

"lost" in the process of referral. Each applicant should clearly describe how continuity of care will be maintained. (For example, each person entering the system may be assigned to a staff member whose responsibility is to assist that client in receiving all the care he requires. The staff member acts as an expediter, advocate and coordinator for his clients. If appointments are not kept by a client anywhere in the systems, the appropriate staff member would be informed of this and provide follow-up.))

4) Submit detail plans for follow-up on clients who have left the project and specify criteria for discharge from the program.

F. Staffing and Training

1) Describe the allocation of staff; i.e., the number, types and responsibilities of staff who will provide care and services. (An organizational chart should be used together with a statement of responsibilities of the various positions listed in the application.) Also state the qualifications (in terms of training and experience) required for each position. (Submit job descriptions for each position.)

(In the selection of project staff, consideration should be given to the employment of a multidisciplinary staff, utilizing degreed and non-degreed professionals including recovered alcoholic persons. Staff should be representative of the demographic -- including ethnic -- composition of the community.)

2) Describe anticipated staff training needs and plans for adequate training and orientation. Provisions should be made for the continued training of staff and for the development of an organizational structure which permits promotion to positions of increased responsibility based on experience and additional training.

G. Describe (do not merely list) service and alcohol abuse and alcoholism treatment and rehabilitation programs available in the community. Show how these existing service providers will be utilized by or coordinated with the proposed project, and include all service agreements.

H. Contracted Agencies

A contracting agency is any agency other than the applicant which will provide services on a reimbursement basis to the applicant or whose staff positions are included in the applicant's budget. Contractors must meet similar requirements as are imposed upon the applicant agency, including adherence to assurances, project reporting and fiscal responsibility, etc.

The contract must include a specific description of the services to be delivered, who will deliver them and the coordinated approach to be used. Prior approval must be obtained before contracting with another agency for provision of the services to be provided under the grant proposal.

INSTRUCTIONS FOR THE COMPLETION OF THE ALCOHOL SERVICES APPLICATION FOR FUNDS

ADIS application format has been developed to provide a section for a description of each segment of a comprehensive alcohol service program. The application has 17 parts and under part #1 there are sub-parts A through H. The instructions are numbered in this manner and program responses should be numbered accordingly. The entire application must be typed on as many 8½ x 11 white sheets as necessary. All information requested must be included in this application. Do not refer to previous documents.

ITEMS FOR PROGRAM RESPONSE

1. Applicant Agency - The official name of the organization requesting alcohol funds.

2. Project Director - The paid employee who has the primary responsibility for implementing the goals of the project.

3. Official Authorized to Sign - The person elected to the highest office of the governing body for the project.

4. Project Title - This may be the same as item i., but may be a subpart of the applicant agency and if so, should be defined.

5. Financial Manager - This would be the paid employee who has primary responsibility for establishing a fiscal control system, maintaining fiscal control and preparation of all fiscal reports.

6. Type of Applicant - This section refers to the formal structure of applicant agency, i.e. government agency, not for profit agency or profit agency. A not for profit agency must submit a copy of the charter filed with the Secretary of State and the IRS tax exempt declaration or documentation that the IRS has received a request for such a determination.

7. List the Counties Served by this Project - This refers to counties having formal contracts for the utilization of the project services.

8. Contract Duration - The specific period of time during which the requested funds will be utilized.

9. Total Amount of this Request from Department of Institutions - This section has 5 separate parts. The first line refers to the exact amount of funds that the project hopes to receive from the Department. The second line refers to the exact amount of cash match that has been granted for the fiscal year, and is being pledged as part of this request. The third line is the total of the requested amount and the cash match. The fourth line is for the grand total of the project budget for the time period described in

U.S. [illegible] and all other alcohol beverages. The intent of this item is for a listing of the sources and amounts of all other funding that is a part of the total budget for the period of time described in Item 8.

10. Applicants Agreement - This is a commitment and should be signed by the official listed in item #3.

11. Budget for Utilization of Requested Funds - This item will show the total budget for the time period described in item 8. It shows the relationship between the requested funds, the cash match and all other funds that will be available. Each expenditure category is to be used for very specific expenses. These specific expenses, by category, are as follows:

PERSONAL SERVICES

Salaries - Regular, overtime, sick leave, vacation, holiday, military leave, jury duty, professional, non-professional, part-time.

Hourly Wages - Regular, overtime, sick leave, vacation, holiday, military, jury duty, general.

Other Compensation - Per diem, general.

Employee Benefits - FICA, retirement, group insurance, workmen's compensation insurance, bonds surety, professional, non-professional hourly wages, unemployment compensation, state unemployment tax, general.

OPERATING EXPENSES

Contracted Services - Consultant and professional services, data processing services, insurance and bonds, janitorial and caretaker services, laundry, legal fees and court costs, physical examination, printing, electrical inspection services, payroll service fees, photographic services, medical services, board and room, storage fees, audit fees, publicity, exhibiting, film services, fire suppression services, honorariums, education and training, general.

Supplies and Materials - Athletic and recreational, clothing and personal, food, housekeeping, janitorial, medical, minor tools and instruments, office, photo and reproduction, professional, printing, pamphlets, books, building materials, radio supplies/ minor equipment, shop supplies/tools/minor equipment, microfilm supplies, film processing supplies, patient apparel, shoes, meat, dairy, produce, bakery, laundry, linens and bedding, kitchen supplies and utensils, general.

Communication - Telegraph (local and long distance) and equipment, telephone (long distance), postage and mailing, freight and express, radio services, post office box rental, advertising (radio and TV), telephone line rental, general.

Travel - In state personal car mileage, in state commercial transportation, in-state meals and lodging, in-state other, General.

Rent - Land, buildings, data processing equipment, office equipment, other equipment, postage meter, vehicles (non-travel), education and recreational, mobile trailers, small equipment, storage, general.

Utilities - Electricity, heating fuel, natural gas, water and sewage, garbage and trash removal, general.

Repair and Maintenance - Buildings and grounds, office equipment, minor tools and instruments, photographic equipment, batteries, broom fillers, patient equipment, paint buildings, fence materials, sign material, data processing equipment, hospital furnishings, fixtures and equipment, educational equipment, general.

Other Expenses - Dues, subscriptions, taxes, assessment and etc., money order fees, registration fees for training conferences, rewards, tuition, recruiting, general.

Equipment - Data processing, educational and recreational, household, medical, office duplicating, photographic, hospital, fire suppression equipment, general.

Items 11-A through 11-G are budget pages that support and document the budget figures listed in items #9 and #11.

12. This item seeks full information on funds being requested from other funding agencies, i.e. - Federal sources, other state sources, local government sources, etc. List and describe all pending applications.

13. Audit - This pertains to programs that have been in operation prior to the projected time period. Future audits should not be included in the budget (item #11). The Department will pay for or provide this service.

14. Cash Match - County funds being used for match must be documented by a letter of intent signed by the Chairman of County Commission. All other funds being pledged as match must be documented, as to their availability, by a letter from a Certified Public Accountant.

15. Liability Insurance - Units of government omit this item. Applicant agencies listed as profit or not for profit must provide documentation of this insurance coverage. A photo copy of the insurance face page of the policy or similar instrument provided by the insurance agent.

16. Transportation of Clients - The Board of directors policy statement covering the transportation of its applicants is to detox facilities, to treatment facilities and any other situations requiring the transportation of clients.

17. This section of the RFP is where you describe the area to be served, the services to be provided, the people to do the providing and all other aspects of the proposed project. Item 17-D refers to "GOALS AND OBJECTIVES", there is a special attachment, with that number, to assist with this material. Item 17-E refers to a "CLIENT FLOW CHART", which describes the sequence of services that will be provided. There is a special sample with that number to assist with this concept.

MONTANA STATE PLAN FY 76

POLICIES FOR THE ALLOCATION OF ALCOHOLISM FUNDS

FROM THE DEPARTMENT OF INSTITUTIONS

1. Requests for the alcoholism program funds should be in writing and directed to Alcohol Services, Department of Institutions, on the forms and in a format prescribed by the Department.

2. These funds may provide for all expenditures for (Section 3, House Bill 748, 1974 Legislative Session-signed March 22, 1974):

   a. personal services
   b. all other ordinary and necessary expenditures for the operation of the agency and the program to which the appropriation applies.
   c. repairs and maintenance other than major alterations of existing buildings.
   d. the purchase of replacement of capital items other than expenditures for the construction, improvement or furnishing of buildings or purchases of buildings or land unless specifically authorized.

3. The local agency requesting these funds must provide one-third cash match before any funds can be authorized. (See above citation.)

   a. In kind or soft match will not be acceptable.
   b. None of the funds being offered as match may have been pre-

viously used as match and must be available for expenditure during the same fiscal year as the requested state funds.

*c. The Department will require a written statement signed by a certified public accountant indicating that the match is available and meets the above conditions.

4. The local agency requesting these funds must provide documented assurance that fiscal records of the expenditures from these funds will be maintained for five years after the fiscal year of funding and be available for review at the request of the Department.

5. The expenditure of these funds must be recorded distinctly from all other funds so as to maintain a clear audit trail.

   a. Co-mingling of these funds with other funds is not acceptable.

6. The local agency requesting these funds must submit a detailed budget and narrative describing how the funds will be used. Such budget should reflect all funding sources utilized by the local agency.

7. The local agency requesting these funds must describe the internal procedure for changing, modifying or amending this budget.

8. A program must submit written consent signed by the chairman of the

board indicating that the program may be audited by the legislative auditor (Section 69-2310, R.C.M. 1947).

*a. The program must provide a certified audit completed within the previous 12 months with application for approval.

*9. A local program must show that it has at least $300,000 liability insurance on its buildings, its premises and any vehicles used for the transportation of clients, including staff-owned vehicles. (JCAH, pp. 15, I.D. 8)

*10. A program must submit proof of Internal Revenue Service tax exempt status or application for such status.

11. These state funds may not be used for fines, penalties, interest, loans, gratuities, and may not be used to repay bad debts or prior financial obligations.

12. These funds may not be used to purchase motor vehicles.

13. Should a program cease to operate or cease to provide alcohol rehabilitation services, capital goods with a new purchase price of $100 or more purchased with these funds will become the property of the State of Montana or must be allocated to another IRS tax exempt agency providing alcohol rehabilitation services.

14. The amount of money that may be reimbursed for travel and per diem costs may not exceed the specified state rate.

15. Each program must have a formal evaluation component and must submit written evaluation reports describing how the program is meeting its stated goals and objectives and if not, why not.

16. Recovering alcoholics, hired as staff for local programs, must have maintained sobriety for at least one year. (Cit. Alcohol and Drug Dependency Advisory Council Minutes dated July 20, 1972.)

17. The local program must define in writing its own policies pertaining to transportation of clients.

18. Each program should provide a written periodic review of the per capita cost of care with definition of various items included. This periodic review should be submitted at least annually and should describe the cost per client for each program component, and how such costs were determined.

19. Each program will be required to submit minutes of its board meetings, quarterly narrative and fiscal reports concerning the expenditure of these funds, and a final report within 30 days of the end of the contract. The programs will also submit other data as may be required.

* These items not required from city, county city-county or multiple county government units.

YES	NO	Planning Section
		Does the application from the Applicant Agency include:
		(1) A description of the agency's history;
		(2) a description of the various components of the agency, plus an organization chart.
		(3) Is there a description of the physical areas to be served by mental health region?
		(4) Is their an estimated number of risk persons and/or alcohol abusing population estimate?
		(5) Does this grant application propose to reach any ethnic or sub-populations already served by an existing program?
		(6) Is the number of clients, (target population) expected to be reached, clearly stated?
		(7) Is their a description of the facilities, which includes: (a) location (s) (b) accessibility to consumers
		Project Goals & Objectives
		(1) Is there a clear, concise, statement of the applicants philosophy of working with alcohol abusers and their families?
		(2) Is the following information in the application regarding the goals and objectives? (a) Are project goals listed? (b) Are objectives listed as to how goals will be accomplished? (c) Are the goals and objectives measurable by time lines, number of persons reached, etc.?
		(3) Is there a division of staff labor toward the achievment of objectives? (this should be shown by a chart or graph)
		(4) Is there a project evaluation section to facilitate the following: (a) Some effectiveness measure of theroputic models on client behavior? (b) An ability to evaluate progress toward specific goals and objectives. (c) Is there a written plan for client follow-up once they leave the program?
		(5) Is criteria for discharge from the treatment program clearly stated?

(1) Does a description of staff members, types, and responsibility accompany the application? (Such as an organizational chart)

(2) Is the staff sufficient in number to meet the program (s) treatment goals?

(3) Is there a section describing anticipated staff training needs?

(4) Is the treatment plan consistent with the stated treatment philosophy?

(5) Are there contractual agreements with other service agencies, such as Vocational Rehabilitation, hospitals, etc.?

(a) Does the applicant appear to be involved cooperatively -via contract or other agreement - with providers of other services in his/her communit

Budget Section (No.)

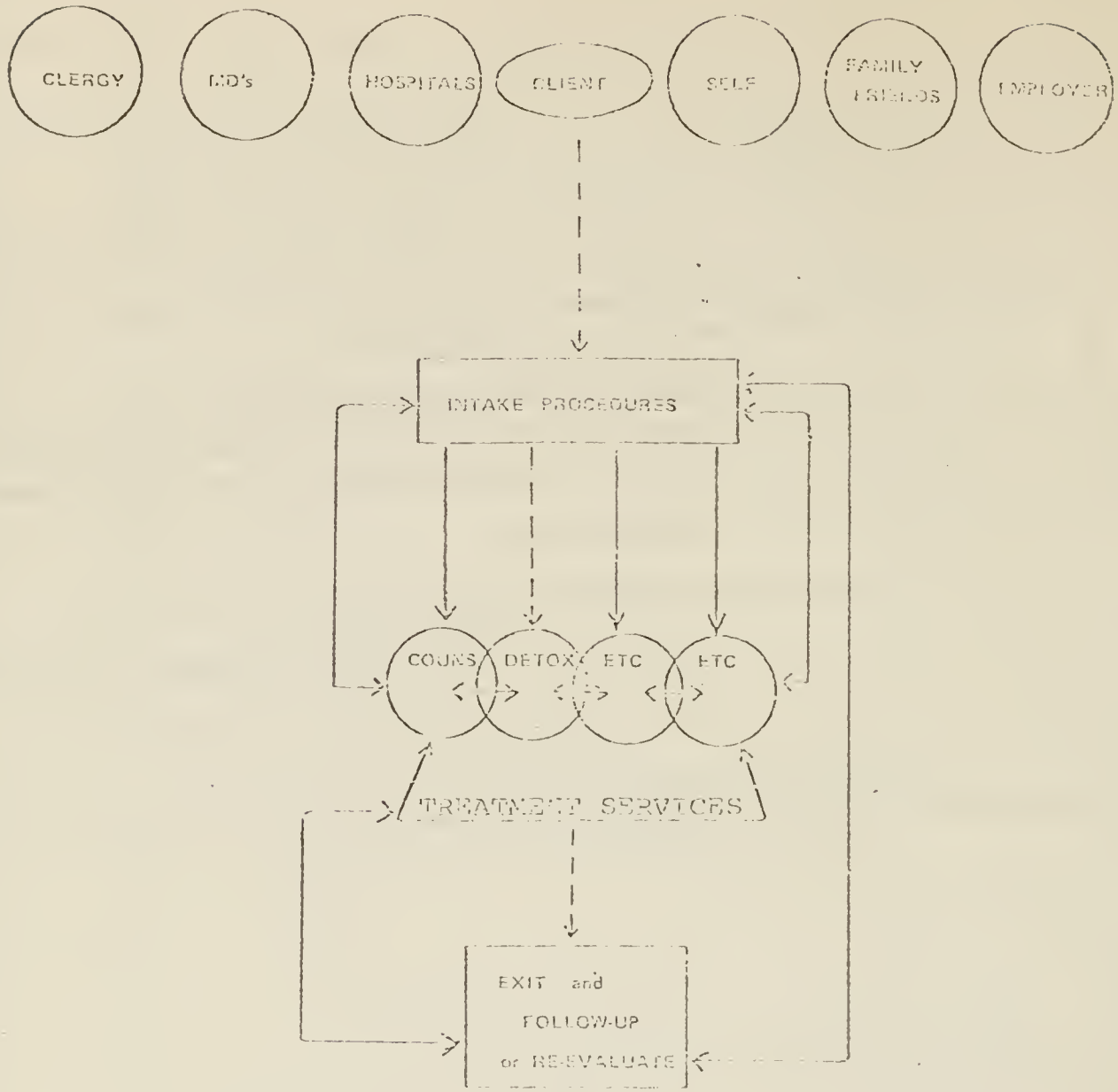
(1) Is the required match shown in the budget and is it documented?

(2) Are the sources of applicant funding dollars clear, specific, and documented?

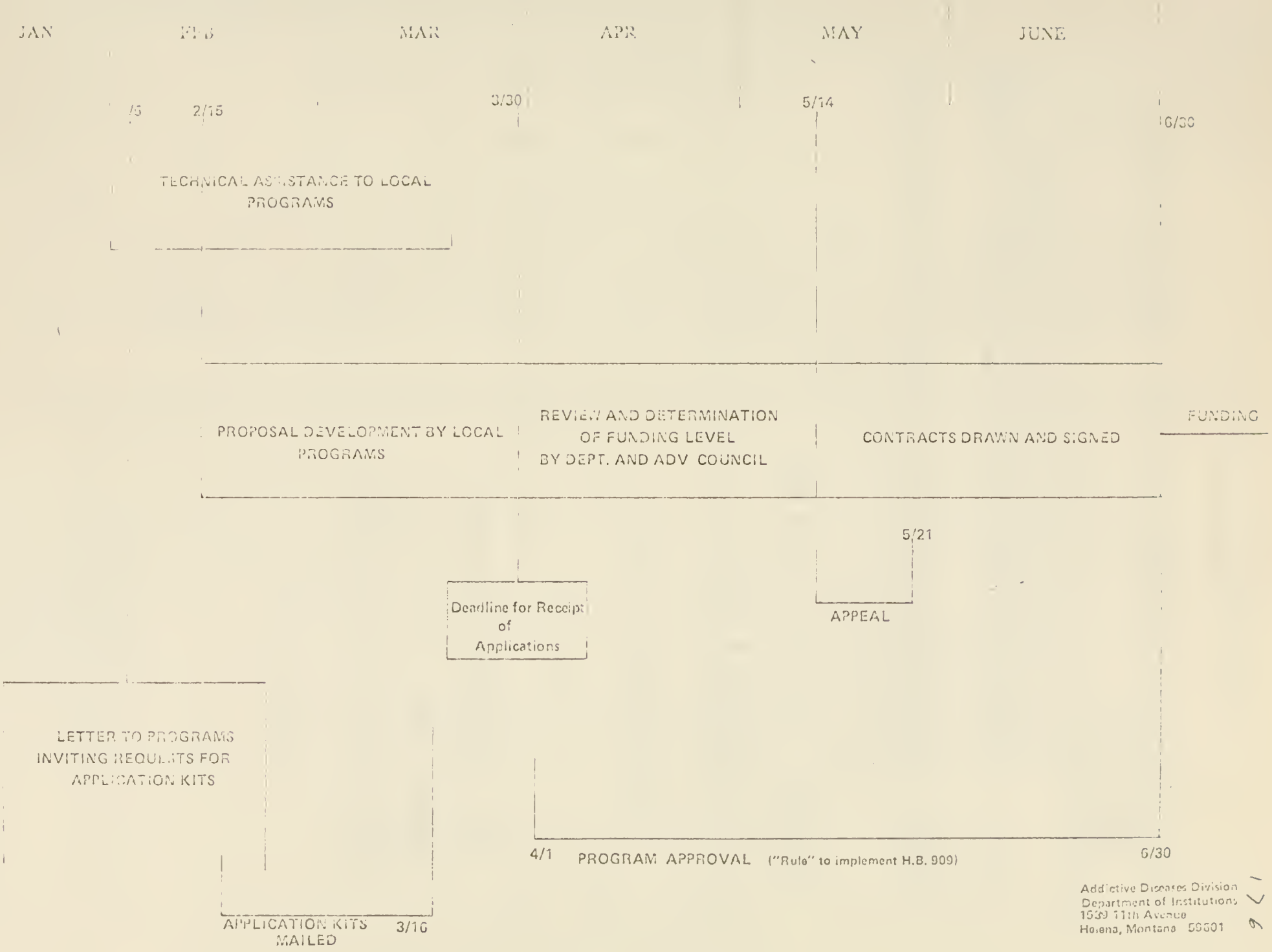
(3) Does the budget total correlate with the amount of funds requested?

(4) Is there a cost per client formula?

(5) Is the budget justification complete? Does it explain the items?



In a flow chart you need to indicate how clients come into your system; what happens (treatment) to them while in the system. That is, how do you decide what treatment modality to use, and how do they either exit the program or re-enter after another evaluation. The keys to the system are intake, treatment services, and follow-up.



Addictive Diseases Division
Department of Institutions
1539 11th Avenue
Helena, Montana 59601

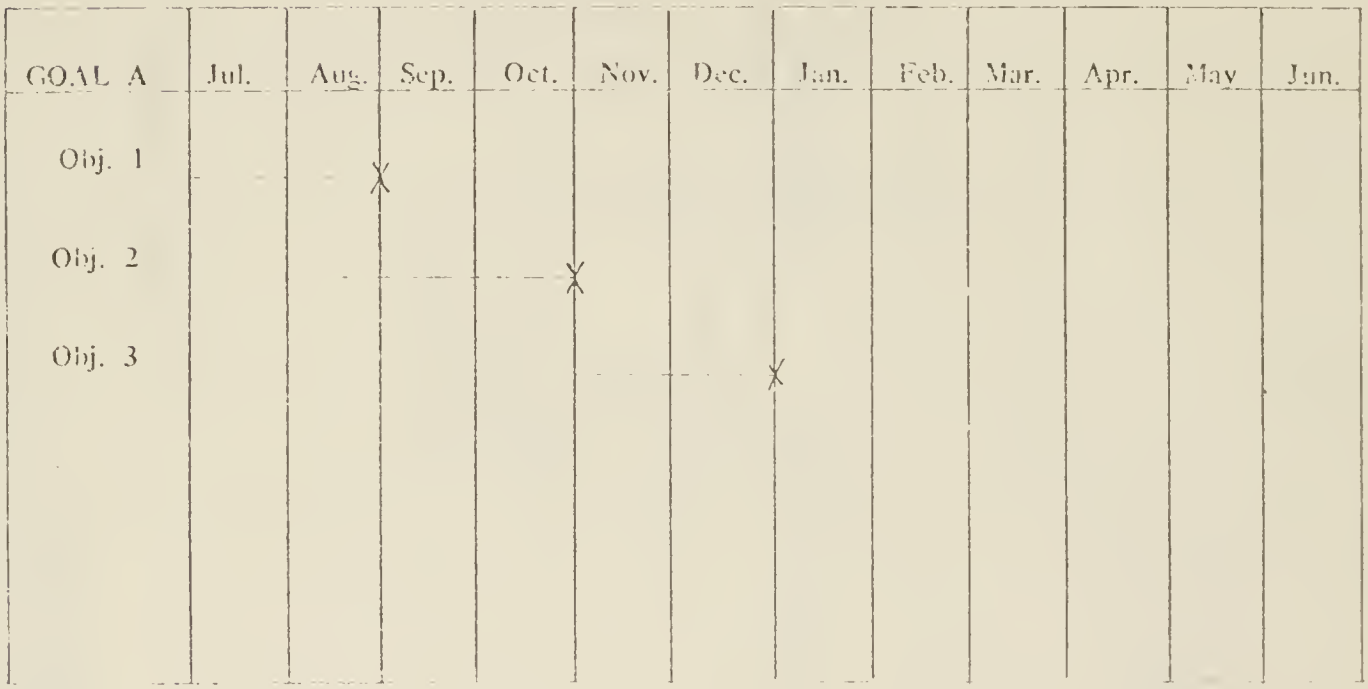
9 7 1

GOALS, OBJECTIVES AND TIMETABLES

GOALS: Is a general statement of what you intent to do. (Example: Alcohol treatment services will be provided by the Care Halfway House within Podunck County.)

OBJECTIVE: Is much more specific than a goal. A well stated objective leaves little to be said about exactly WHAT will be done, HOW this will be measured, WHEN it will be accomplished and WHO is responsible for its accomplishment. (Example: Objective 1. By September 1, 1976 the Care Halfway House will hire two counselors. Objective 2. By November 1, 1976 the Care Halway House will have ten residential alcohol clients.)

TIMETABLE: Several objectives may be required to fullfill one goal. When all objectives have been completed, the goal will be accomplished. Timetables for objective accomplishments can be specified in a chart as shown below.



TUESDAY, JULY 1, 1975

WASHINGTON, D.C.

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PART IV

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Public Health Service

□

CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS

General Provisions

Reprinted by

U.S. Department of Health, Education, and Welfare
Public Health Service
Alcohol, Drug Abuse, and Mental Health Administration
National Institute on Drug Abuse

GOALS: Is a general statement of what you want to do. (Example: Alcohol treatment services will be provided by the Care Halfway House in Portland County.)

OBJECTIVE: Is much more specific than a goal. A well stated objective leaves little to be said about exactly WHAT will be done, HOW this will be measured, WHEN it will be accomplished and WHO is responsible for its accomplishment. (Example: Objective 1. By September 1, 1976 the Care Halfway House will hire two counselors. Objective 2. By November 1, 1976 the Care Halfway House will have ten residential alcohol clients.)

TIMETABLE: Several objectives may be required to fulfill one goal. When all objectives have been completed, the goal will be accomplished. Timetables for objective accomplishments can be specified in a chart as shown below.

GOAL A	Jul.	Aug.	Sep.	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.	Apr.	May	Jun.
Obj. 1	-	-	X									
Obj. 2		-			X							
Obj. 3						-	X					

SECTION 8

8.1 CERTIFICATION OF PERSONNEL

8.2 STANDARDS FOR APPROVAL OF PROGRAMS

STANDARDS

The standards for the approval of alcoholism programs have been listed in section 7 of this plan.

The standards for the certification of alcoholism workers have not been developed into a final document at the time of this writing. The Alcohol Programs of Montana, Inc., the association of program directors, has undertaken the function of researching the standards being used in other states and establishing a model set of standards that could be considered for use in Montana. When these standards have been developed, a copy will be made available to the regional office and other interested persons.

The purpose of this booklet is to develop a format which will enable you to understand with greater clarity the "Standards for Approval of Alcohol Programs - Rules for Implementing Sections 80-2713, 80-2714, and 80-2715 R. C. M. 1947 (HB 909)*

The Rules for Implementing Sections 80-2713, 80-2714 and 80-2715* R. C. M. 1947 (HB 909)" are presented in this booklet verbatium and in their entirety. However, the format has been simplified. The Sections labled compliance (all in italic print) have been added in order for programs to more fully comprehend the implementing requirements of the rule.

THE APPROVAL PROCESS

(1) Compile the required information designed in the compliance section of the booklet.

(2) Submit a written request for approval.

(3) A staff member(s) of the A.D.B. will conduct an on-site review to determine compliance. Please do no submit the required information but have it available during the on-site review. At this time the A.D.B. staff member(s) and alcohol program staff will go through the entire compliance procedure together.

The deadline for approval is 6-30-76. However, we would appreciate your requests as soon as possible, in order to schedule programs accordingly.

All grandfather clause approvals will expire 6-30-76 and approval through 6-30-77 must be obtained before awarding our General Fund Contract.

* Note: The above sections were previously labled 69-6216, 69-6217 and 69-6218.

(1) Purpose.

The purpose of this rule is to establish treatment standards for the approval of programs extending treatment services to alcoholics, intoxicated persons and persons incapacitated by alcohol pursuant to Section 80-2913, R. C. M. 1947, and standards for acceptance of persons into the treatment program, and standards by which the administrator may determine which persons may be admitted to an approved public treatment program as an alcoholic pursuant to Sections 80-2714 and 80-2715, R. C. M. 1947. Prior to approval and prior to being designated as part of the state program for treatment, each facility shall be licensed in accordance with Section 69-5203, R. C. M. 1947.

(2) Definitions. In addition to the terms defined in Section 69-6212, R.C.M. 1947,

"administrator" - means the person in charge, care or control of the treatment program and responsible for the operation of the program.

"care" - means services provided by trained personnel, such as nurses, aides, alcoholism helpers or counsellors.

"department" - means the Department of Health and Environmental Sciences.

"emergency treatment program" (non-hospital) - means a program which is advertised, announced or maintained for the expressed or implied purpose of providing individuals admitted there with short term residence, nursing, convalescent or rehabilitative care, supervision and care incidental to withdrawal from alcohol.

"intermediate treatment program" - means a community-based residential program providing therapeutic services including supervision and an opportunity for relearning social skills to assist clients to return to the community. Services are provided for the individual who needs less direct supervision than emergency treatment and more services than available through an outpatient program.

"inpatient treatment program" - means a program providing a residential setting for clients who require continuous care and treatment with specific therapeutic functions beyond those offered by emergency, intermediate, or outpatient programs.

"outpatient treatment program" - means a program providing counselling and outreach services for individuals who are able to function without the structure of emergency intermediate or inpatient treatment programs.

"physician" - means a physician licensed by the State of Montana.

"outpatient" - when used to modify a person, facility or service means a person who is not a resident of a treatment program.

"patient" - means a person who is formally diagnosed as in need of and admitted to a treatment program.

"person" - means an individual or group of individuals, association, partnership or corporation.

"resident" - means any person assigned, living or residing in a dwelling or rooming unit or a treatment program.

"treatment facility" - means any public or private place, establishment, building, rooming house, boarding house, lodging house, dwelling, home, farm, camp or other facility by whatever name known used to provide treatment services as an emergency and receiving facility, halfway and rehabilitation facility or comprehensive treatment center providing any or all of the following services to alcoholics, intoxicated persons, or persons incapacitated by alcohol: emergency, inpatient, intermediate or outpatient treatment. Non medical facilities of eight (8) beds or less are not subject to facility licensure rules.

(3) Requirements for approval of alcohol treatment programs.

Each public or private program providing services for alcohol treatment shall be subject to approval by the department. A certificate of approval shall be obtained annually. The certificate issued shall be conditional to establishing and operating programs in compliance with the rule.

(a) If a treatment program is determined to be in compliance with state requirements and applicable federal requirements, the department shall issue the certificate of approval to the program. This certificate shall be displayed in a conspicuous place of the program for which it is issued.

(b) Each certificate of approval shall be valid only in the possession of the person to which it is issued and shall not be subject to sale, assignment or other transfer, voluntary or involuntary, nor shall a certificate be valid for any location other than that for which it is issued.

(c) Each certificate of approval shall be for a period of one year from the date of issue unless revoked or suspended.

(d) Each certificate of approval shall be renewed annually. Each application for renewal shall be submitted on the form provided by the department not less than thirty (30) days prior to expiration.

(e) Programs in existence as of January 1, 1975 will be fully approved by must meet the standards of these rules within eighteen (18) months of the effective date of this rule. A contract/agreement shall be written between the department and the program in question stipulating specified objectives to be met within a definite time period for continuing approval. An orderly progression shall be set forth with time limits for the program to meet acceptable standards.

(f) Additional data, statistics, schedules and/or information shall be filed by the applicant as may be reasonably required by the department for the purpose of determining the applicant's conformance with this rule.

(4) Acceptance of persons into the treatment program.

(a) Voluntary treatment shall be encouraged and maintained when possible.

(b) Programs shall admit and care for only those persons for whom they can provide care and services appropriate to a person's physical, emotional and social needs.

(c) If an alcoholic is not admitted to an approved public treatment program for the reason that adequate and appropriate treatment is not available at that program or facility, the administrator shall refer the person to another public treatment program at which adequate and appropriate treatment is available.

(d) Any restrictions, priorities or special admission criteria used during initial screening shall be applied equally to all potential admissions regardless of source or referral, source of payment, race, creed, ethnic origin or sex.

(e) A person who, by evaluation, is found to require outpatient or intermediate treatment shall be initially assigned to a program providing such treatment or transferred to a program providing the appropriate treatment. If a person is found to require inpatient treatment, such treatment shall be made available to him.

(f) A program shall not prohibit a person from subsequent participation where the person has withdrawn from prior treatment or has relapsed after earlier treatment.

(g) An individualized treatment plan specifically tailored to meet the needs of the individual patient/client shall be prepared and maintained on a current basis for each patient/client.

(h) The staff of a program shall develop an appropriate referral plan for the resident deemed necessary to effect total and complete recovery and rehabilitation. Staff shall actively assist residents to make contact with clinics, Alcoholics Anonymous, social and welfare agencies, and other approved treatment programs suitable for follow-up care upon discharge from the program.

Compliance:

Develop a policy or statement which includes the following assurances:

a. Encouragement of voluntary treatment.

b. Only treat client when need is appropriate.

c. Referral to appropriate treatment.

d. No discrimination.

e. Assignment to the appropriate type of care by evaluation and making available that type of care, if possible.

f. No restriction to reperaters.

g. Maintenance of a current individualized treatment plan.

h. Presence of a procedure for appropriate referral to other community agencies.

(5) Administrative management - - governing body.

(a) A program shall have a governing body which is legally responsible for the conduct of the program.

Compliance:

Submit a policy or statement which states in effect that the governing body is legally responsible for that conduct of the program.

(b) The governing body shall establish a philosophy of policies and goals.

Compliance:

Submit a policy which reflects the governing body's philosophy of policies and goals.

(c) Policies shall be in writing governing admissions, discharges, length of stay, diagnostic groups to be served, scope of services, treatment regimens, staffing patterns, recommendations for continued treatment by referral or otherwise, and provision for a continuing evaluation of the program.

Compliance.

Submit documentation of written policies and procedures. The following procedures should be included:

Admission procedure

Discharge procedure
Policy and length of stay
Policy on diagnostic groups to be served
Scope of services
Treatment regimens
Staffing patterns
Recommendations for continued treatment by referral or otherwise
Evaluation component

(d) The governing body shall be responsible for providing personnel, facilities, and equipment needed to carry out the goals and objectives of the program and meet the needs of the residents.

Compliance:

Documentation not necessary but licensure by the Department of Health and Environmental Sciences, Hospital and Medical Facilities Division, Licensing Bureau, is mandatory for in-resident programs.

(e) The governing body shall appoint an administrator. Policies shall be in writing governing the qualifications and responsibilities of the administrator.

Compliance:

Submit a job describtion for administrator.

(6) Operational requirements for resident programs. (This section applies to resident programs only)

(a) Food Service

(i) Food shall be provided and shall be wholesome and nutritionally balanced. Three meals or equivalent shall be served daily at regular times. Snacks shall be available to residents at all times.

(ii) Food not prepared on site shall be obtained from approved sources and shall be transported and served in an approved manner.

Compliance:

Submit:

(i) A 30 day menu for meals and snacks?

(ii) If food is not prepared on site, supply name of source, and method of transportation and service.

(b) Personal Hygiene.

(i) Clean clothing, drinking cup, towels, soap, toothbrushes, combs, toothpaste or toothpowder, shaving equipment and other personal articles as required shall be available to each resident for his individual use.

Compliance:

Submit a policy or statement which states the above items are made available to individual clients.

(c) Medical.

(i) Medical services shall be available under the supervision of a physician, and any resident at his own expense shall have the right to consult with the physician or dentist of his choice.

Compliance:

Submit documentation that medical service is available under the supervision of a physician and a policy stating that any resident at his own expense shall have the right to consult the physician or dentist of his own choice.

(ii) Written medical policies and procedures shall be readily available to staff. Written medical policies and procedures as to the course of action to be followed in the care of occupants having minor acute illnesses and in the event of medical emergencies including dangerous behavior shall be developed with the assistance and written approval of a physician or a representative of the medical board.

Compliance:

Submit documentation of written medical policies and procedures developed with the assistance and written approval of a physician or representative of the medical board. Included within these written medical policies and procedures care of occupants having minor acute illnesses and in the event of medical emergencies including dangerous behavior.

(iii) Arrangements for access to medical and surgical care shall be made with a general hospital for residents when it is needed. The program is not required to assume responsibility for the cost of such care.

Compliance:

Submit a written agreement with local hospitals for medical/surgical care when needed?

(iv) Personal observation and inquiry shall be made of each person upon admission as to chronic illness or physical disability or vermin infestation or possible contagious disease that may require medical attention. Such medical attention shall be immediately made available when necessary and no person shall be admitted who is in need of medical services for a severe physical or emotional illness including severe alcohol intoxication or its withdrawal symptoms except in a program capable of providing the necessary services. The program is not responsible for the cost of such care.

Compliance:

Submit an admission procedure which allows for personal observation and inquiry. The following items shall be included:

History of chronic illness
Physical disability
Vermin infestation
Possible contagious disease

Include a written assurance that such medical attention will be immediately available when necessary and no person shall be admitted who is in need of medical services, unless provided by the proper service component.

(v) First aid equipment and supplies shall be provided and shall be available for emergency and routine use conforming to written procedures.

Compliance:

Documentation that first aid equipment and corresponding written procedures are present.

(vi) Arrangements for access to dental care shall be made available for the relief of pain and control of infection. The program is not required to assume responsibility for the cost of such care.

Compliance:

Submit a policy which assures the availability of dental care.

(vii) Mental health consultation shall be made available for emergencies. The program is not required to assume responsibility for the cost of such services.

Compliance:

Submit a written agreement with Mental Health for emergency consultation, and/or a policy assuring this.

(viii) Medications shall be handled in accordance with provisions of applicable state and federal laws and regulations.

(ix) Medications purchased independently by a resident or supplied by his physician or medicines used by the resident shall be stored in such a manner that the use of such materials can be restricted to self administration by the resident.

(x) Methods for cleaning, handling and storing of all medical supplies and equipment shall be such as to prevent the transmission of infection through their use.

Compliance:

Submit a procedure for the administration of medication, which specifies who administers the medication, and the method of handling, storage and acquisition. Programs dispensing medication will have an on-site inspection of the methods of handling, storage and administration.

(d) Responsibility.

(i) Policies and procedures shall be established by each program to insure proper environmental and personal health conditions for protection of the health of the residents.

Compliance:

Submit documentation of policies and procedures which insure proper environmental and personal health conditions for the protection of the health of the residents.

(7) Records and Reports.

(a) Residents' records: Residents' records shall be handled and stored in such a manner as to properly safeguard the confidentiality of their contents. Each resident's records shall include at least the

following:

(i) Identifying information including either name or identifying number, age sex, and marital status.

(ii) Social history.

(iii) Dates of admission and discharge.

(iv) Records of medical care, including physical examiniations and medications taken.

(v) Records of illnesses.

(vi) At least semi-monthly written progress reports on each resident as applicable by program staff, plus a termination report.

(vii) An individualized treatment plan containing both short term and long term goals.

Compliance:

Residents/client records shall be handled and stored in accordance with the confidentiality regulations ( ).

The following shall be included in the residents/clients records:

(i) Identifying information
(ii) Social history
(iii) Dates of admission and discharge
(iv) Records of medical care including physical examination and medications
(v) Records of illnesses
(vi) At least semi-monthly progress report, Termination report and/or discharge summary
(vii) An individualized treatment plan

Addresses individualized needs
Short term and long term goals and objectives
Evidence of client participation
Demonstrates continuity of care

(b) Other records and reports. The following other records and reports shall be available for review by the department:

(i) Resident admission register.

(ii) Articles, by-laws, rules and regulations, minutes of meetings of the governing body, and operational policies established by the governing body of the treatment program.

(iii) Written job descriptions for personnel.

(iv) Formal written agreements for contracted services.

(v) Record of menus served during the previous 30-day period.

(vi) Records or reports reasonably required by the department.

Compliance:

Self Explanatory.

(c) Confidentiality: Patient record information may be maintained or disseminated, by compulsory process or otherwise, outside the patient's treatment program which collected such information, only as provided in accordance with section 333 of P. L. 91-616, the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 (84 Stat. 1853, 42 U.S.C. 4582), as amended by section 122 (a) of P.L. 93-282, The Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act Amendments of 1974.

Compliance:

Patient record information is maintained and disseminated, only as provided in accordance with Section 333 of P.L. 91-616.

(8) Requirements specific to emergency treatment provided by a program affiliated with or part of the medical service of a general hospital.

(a) An emergency treatment program may be provided in a non-hospital or hospital-based setting. That program shall provide residents with short term supervised care incidental to alcoholism or alcohol abuse. An emergency program shall be in a place where an alcoholic, intoxicated person or person incapacitated by alcohol can be:

(i) Sobered up in a safe environment and protected from the dangers of his drunken behavior to himself and others.

(ii) Protected from developing the sometimes life threatening mental and physical symptoms that ensue when a habitual excessive drinker abruptly terminates his drinking.

(iii) Screened for the presence of the diversity of medical and surgical conditions that are often the consequences of drunkenness, alcoholism or both, and be referred expeditiously to a hospital for definitive diagnosis and treatment.

(iv) Provided with encouragement, advice, counselling and referral to other treatment and service facilities and agencies for help in controlling his alcohol problem if he has one.

Compliance:

Explain the setting and its relationship with the hospital.

Develop a policy or statement which offers the following assurances and services for clients:

(i) Sobering up in a safe and protected environment.

(ii) Protection from the development of sometimes life-threatening mental and physical symptoms.

(iii) Screening for the presence of medical-surgical conditions often associated with alcoholism or as a consequence of drunkeness and expeditious referral if warranted.

(iv) Encouragement, advice, counseling, and referral in helping the individual control his drinking problem.

(b) Program. An emergency treatment program shall be available on a 24-hour day, 7 - day a week basis. The program shall have a written plan for the admission, care, treatment and discharge of all clients.

(i) A record shall be made of the resident's clothing and valuables and signed by the resident or sponsor and a staff member of the program.

(ii) Counselling staff shall be available to provide appropriate evaluation, counselling and referral.

(iii) An individualized treatment plan shall be prepared and maintained on a current basis for each client.

(iv) A minimum of one staff member shall be on duty for admitting, treating and discharging purposes. Adequate staff shall be provided to guarantee care as defined in this section.

Compliance:

Submit an assurance that service is provided on a 24 hour, 7 days a week basis.

Submit written plans and procedures for the following:

Admission
Care
Treatment
Discharge

The following requirements must be included within the treatment component:

(i) A record of the resident's clothing and valuables, signed by the resident or sponsor and a staff member.

(ii) Counseling staff available to provide appropriate evaluation, counseling and referral.

(iii) A current individualized treatment plan.

(iv) A minimum of one staff member on duty for admitting, treating, and discharge purposes.

State how many.

IN PATIENT TREATMENT COMPONENT

(9) Requirements specific to inpatient treatment programs.

(a) An inpatient treatment program is defined as a setting for clients who require continuous care and treatment with specific therapeutic functions beyond those offered by emergency or short term programs.

(b) Program. Inpatient treatment services shall be provided on a 24-hour, 7-day a week basis. The program shall have a written plan for the admission, care, treatment and discharge of all clients. The following services and programs shall be provided:

(i) Personnel, facilities and equipment sufficient to carry out a program which will assist the client to regain physical, mental, social and vocational abilities to function in society on a productive basis.

(ii) An individualized treatment plan shall be written to include: evaluation and diagnosis (medical and psychological if required); intensive counselling (individual and group); alcoholism education; referral to specialized resources in the community upon release (or prior to release if appropriate), and a written post-discharge plan focusing on a continuum of alcoholism services. There shall be a referral to a community-based resource such as a local alcoholism program or Alcoholics Anonymous.

Compliance:

(a) Submit a statement or policy which confirms the fact that the inpatient treatment program provides a setting for clients who require continuous care and treatment with specific therapeutic functions beyond those offered by emergency or short-term programs.

(b) Submit documentation which assures that service is provided on a 24-hour, 7-day a week basis.

Submit written plans and procedures for the following:

Admission
Care
Treatment
Discharge

(i) Submit documentation which confirms that personnel, facilities and equipment are sufficient to carry out a program which will assist the client to regain physical, mental social and vocational abilities to function in society on a productive basis.

(ii) Submit an individualized treatment plan which includes the following:

Evaluation and diagnosis
Intensive Counseling
Individual
Group
Family
Alcoholism education
Referral to specialized resources in community.

Referral to community based resources for social alcohol program or Alcoholics Anonymous.
A written post discharge or follow-up plan focusing on a continuum of alcoholism service.

(c) Staff.

(i) The minimum staff shall be determined by the governing body.

(ii) A staff member who is qualified to supervise the residents and the center shall be on duty at all times. In addition, the administrator shall be on call and available for emergencies.

(iii) There shall be an adequate number of qualified staff members in the specialties required by the treatment regimen or regimens of an inpatient treatment program such as alcoholism counsellors, psychologists, social workers, psychiatrists, clergymen, etc. Their qualifications shall conform to the prevailing standards of these specialties with specific training and/or experience in the treatment of alcoholism. This does no preclude the use of residents for work assignments when it is part of the individual's written treatment plan.

Compliance:

Submit documentation for the following staff requirements:

(i) Minimum staff is determined by the governing body.

(ii) A qualified staff member to supervise the residents and the center on duty at all times. The administrator is on call and available for emergencies.

(iii) An adequate number of qulified staff members in the specilities required by the treatment regimen. Include job descriptions and staff qualifications.

(10) Requirements specific to intermediate treatment programs (e.g., halfway house).

(a) Program. Supervision and services shall be available on a 24-hour, 7-day a week basis. The program shall have a written plan for the admission, care, treatment and discharge of all clients. The following services and programs shall be provided:

(i) Counselling staff shall be available to provide evaluation, counselling and referral.

(ii) Recreational and rehabilitation activities shall be planned for therapeutic purposes and shall be under the guidance of program staff. All residents shall be encouraged to participate in appropriate activities, both in the residential program and in the community. The program shall place priority on those activities which will help residents resume normal social life in the community.

Compliance:

Submit a written assurance that supervision and services are available on a 24 hour, 7-day a week basis. Submit written plans and procedures for the following; admission, care, treatment and discharge.

(i) Submit a written list of counselling staff and their duties. These should include evaluation, counselling and referral.

(ii) Submit a schedule for recreational and rehabilitation activities.

(b) A resident shall be required to pay for services rendered within the treatment plan, consistent with his ability to pay or capacity to maintain employment.

Compliance:

Submit a sliding free scale for clients.

(c) In order to maintain residency and be qualified for funding for services, a resident must be formally admitted, there must be a treatment plan and client must participate in the program.

Compliance:

Submit the following:

A formal admission procedure
An individualized treatment plan with evidence of client participation

(d) An individualized treatment plan shall be prepared and maintained on a current basis for each client.

Compliance:

Submit documentation of at least semi-monthly progress notes.

(e) Staff.

(i) A house manager (staffed to provide 24 hour coverage of service). The house manager need not be on duty if the administrator or counsellor is available. The house manager position may include salaried resident employees.

(ii) A minimum of one staff member shall be on duty for admitting, treating and discharging purposes.

Adequate staff shall be provided to guarantee care as defined in this section.

Compliance:

Profile a list of staff members and their responsibilities.

OUTPATIENT TREATMENT COMPONENT

(11) Requirements specific to outpatient treatment programs.

(a) An outpatient program shall provide alcoholism counselling services to those in need and shall include an active outreach philosophy for early identification of individuals showing signs of reduced social/vocational functioning due to excessive drinking.

Compliance:

Submit a statement which defines your philosophy toward the above.

(b) Program. An outpatient treatment program shall be available on a 24 hour a day, 7-day a week basis. A revolving schedule of counsellors may be used to insure a staff member on call at any time. The program shall have a written plan for acceptance to the program, resources available (program or community), referral procedures for more intensive services if needed.

(i) Services shall include appropriate counselling and referral.

(ii) An individualized treatment plan shall be written and maintained on a current basis for each client and shall include follow-up plans.

Compliance:

Submit documentation for the following items:

Availability of service 24 hours a day, 7 days a week.
A revolving schedule of counselors on call.
Written plans for acceptance to the program, resources available and a procedure for referral.

(i) Submit a list of services. (These must include counselling and referral).
(ii) An individualized treatment plan will be reviewed on site by ADB staff. Attention will be directed toward the above items.

(c) Staff.

(i) Counselling staff shall be trained in the field of alcoholism counselling and education and shall demonstrate an abilitiy to work with clients and a knowledge of the etiology of alcoholism.

(ii) Sufficient staff shall be available to provide 24-hour services on call.

(iii) Staff shall be familiar with community resources for referral, if needed (e.g., medical, social, vocational, mental health, A.A., etc.).

(iv) Continuing education in counselling skills shall be made available for staff.

Compliance:

(i) Submit documentation of staff qualifications.
(ii) Submit a list of total staff and their responsibilities re 24 hour service
(iii) Submit a resource list and referral procedure.
(iv) Submit staff policy toward continuing education

4. Policy re: acceptance of persons into treatment program.

YES _____ NO _____

Indicate which of the following are included in the policy:

_____ a. Encouragement of voluntary treatment.

_____ b. Only treat client when need is appropriate.

_____ c. Referral to appropriate treatment.

_____ d. No discrimination.

_____ e. Assignment to the appropriate type of care by evaluation and making available that type of care, if possible.

_____ f. No restrictions to repeaters.

_____ g. Maintenance of a current individualized treatment plan.

_____ h. Presence of a procedure for appropriate referral to other community agencies.

5. Administrative Management - Governing Body

a. Is the governing body legally responsible for the conduct of the program?

YES _____ NO _____

Is the governing body a public or private organization?

Public _____
Private _____

b. Has the governing body established a philosophy of policies and goals?

YES _____ NO _____

c. Documentation of policies and procedures?

YES _____ NO _____

Indicate which of the following are included:

_____ Admission procedure
_____ Discharge procedure
_____ Policy and length of stay
_____ Policy on diagnostic groups to be served
_____ Scope of services
_____ Treatment regimens
_____ Staffing patterns
_____ Recommendations for continued treatment by referral or otherwise
_____ Evaluation component

d. Is the governing body responsible for providing personnel, facilities and equipment?

YES _____ NO _____

e. Did the governing body appoint the administrator?

YES _____ NO _____

Documentation of policies governing the qualifications and responsibilities of the administrator?

YES _____ NO _____

6. Operational requirements for resident programs.

a. Food Service

(i) 30 day menu for meals and snacks?

N/A _____ YES _____ NO _____

(ii) If food is not prepared on site, is it obtained from an approved source?

N/A _____ YES _____ NO _____

b. Personal Hygiene

Are personal articles necessary for proper personal hygiene made available to each resident for individual use?

N/A _____ YES _____ NO _____

c. Medical

(i) Documentation that medical service is available under the supervision of a physician and a policy stating that any resident at his own expense shall have the right to consult the physician or dentist of his own choice.

N/A _____ YES _____ NO _____

(ii) Documentation of written medical policies and procedures developed with the assistance and written approval of a physician or representative of the medical board.

N/A _____ YES _____ NO _____

Indicate which of the following procedures are included.

_____ Care of occupants having minor acute illnesses.

_____ Medical emergencies including dangerous behavior.

(iii) Written agreement with hospital for medical/surgical care when needed?

N/A _____ YES _____ NO _____

(iv) Assurance that personal observation and inquiry is made of each client upon admission.

N/A _____ YES _____ NO _____

The following are included:

_____ History of chronic illness
_____ Physical disability
_____ Vermin infestation
_____ Possible contagious disease

Assurance that needed medical attention is made available whether it be for severe withdrawl or an emotional disturbance.

(v) First aid equipment and corresponding written procedures present.

N/A _____ YES _____ NO _____

(vi) Arrangements for access to dental care?

YES _____ NO _____

(vii) Agreement with Mental Health for emergency consultation?

N/A _____ YES _____ NO _____

(viii) Medications are handled in accordance with provisions of applicable state and federal laws and regulations?

N/A _____ YES _____ NO _____

(ix) The clients own medication is self-administered in the proper manner?

N/A _____ YES _____ NO _____

(x) Proper methods of cleaning, handling and storing all medical supplies and equipment are utilized?

N/A _____ YES _____ NO _____

d. Responsibility

Documentation of policies and procedures which insure proper environmental and personal health conditions for the protection of the health of the residents.

N/A _____ YES _____ NO _____

7. Records and Reports

a. Are the residents/clients records handled and stored in accordance with the confidentiality regulations?

YES _____ NO _____

Indicate which of the following are included in the residents/clients record:

_____ (i) Identifying information
_____ (ii) Social history
_____ (iii) Dates of admission and discharge
_____ (iv) Records of medical care including physical examination and medications
_____ (v) Records of illnesses
_____ (vi) At least semi-monthly progress report
_____ Termination report and/or discharge summary
_____ (vii) An individualized treatment plan

_____ Addresses individualized needs
_____ Short term and long term goals and objectives
_____ Evidence of client participation
_____ Demonstrates continuity of care

b. Other Records and Reports

Documentation of the following for review by the Department.

_____ (i) Resident admission register.
_____ (ii) Articles, by-laws, rules and regulations, minutes of governing body meetings, and operational policies established by the governing body.
_____ (iii) Written job descriptions.
_____ (iv) Formal written agreements for contracted services.
_____ (v) Record of menus served during the previous 30 day period.
_____ (vi) Records or reports reasonably required by the Department.

c. Confidentiality

Patient record information is maintained and disseminated, only as provided in accordance with Section 333 of P.L. 91-616.

YES _____ NO _____

8. The Emergency Treatment Component

a. The emergency treatment program is one of the following:

_____ A non-hospital setting.
_____ A non-hospital setting, but affiliated with a general hospital.
_____ Part of the medical service of a general hospital (hospital based).

The emergency treatment program offers the following assurances and services for clients:

_____ (i) Sobering up in a safe and protected environment.
_____ (ii) Protection from the development of sometimes life-threatening mental and physical symptoms.
_____ (iii) Screening for the presence of medical-surgical conditions often associated with alcoholism or as a consequence of drunkeness and expeditious referral if warranted.
_____ (iv) Encouragement, advice, counseling, and referral in helping the individual control his drinking problem.

b. Program

Does the program provide service on a 24 hour, 7 days a week basis?

YES _____ NO _____

Does the program have written plans and procedures for the following:

_____ Admission
_____ Care
_____ Treatment
_____ Discharge

Indicate which of the following requirements are included within the treatment component:

_____ (i) A record of the resident's clothing and valuables, signed by the resident or sponsor and a staff member.
_____ (ii) A counseling staff available to provide appropriate evaluation, counseling and referral.
_____ (iii) A current individualized treatment plan.
_____ (iv) A minimum of one staff member on duty for admitting, treating, and discharge purposes.

How many? _____

9. Inpatient Treatment Component

a. Does the inpatient treatment program provide a setting for clients who require continuous care and treatment with specific therapeutic function beyond those offered by emergency or short term programs?

YES _____ NO _____

b. Program

Does the program provide service on a 24 hour, 7 day week basis?

YES _____ NO _____

Does the program have written plans and procedures for the following?

_____ Admission
_____ Care
_____ Treatment
_____ Discharge

Indicate which of the following services and programs are provided:

(i) Personnel _____, facilities _____, and equipment _____, sufficient to carry out a program, which will assist the client to regain physical, mental, social and vocational abilities to function in society on a productive basis.

Comment: _____
_____
_____
_____.

(ii) An individualized treatment plan which includes:

_____ Evaluation and diagnosis
_____ Intensive Counseling
_____ Individual
_____ Group
_____ Family
_____ Alcoholism education
_____ Referral to specialized resources in community.
_____ Referral to community based resource i.e. local alcohol program or Alcoholics Anonymous.
_____ A written post discharge or follow-up plan focusing on a continuum of alcoholism service.

c. Staff

(i) Does the governing body determine minimum staff requirements?

YES _____ NO _____

(ii) Is a qualified staff member on duty at all times?

YES _____ NO _____

Is the administrator on call and available for emergencies?

YES _____ NO _____

(iii) Does the program have an adequate number of qualified staff members in the specialties required by the treatment regimen?

YES _____ NO _____

How Many _____ Titles _____

_____

_____

_____

_____

_____

Do the staff members qualifications conform to prevailing standards in these specialties?

YES _____ NO _____

10. The Intermediate Treatment Component

a. Program

Supervision and services are available 24 hours a day, 7 days a week.

YES _____ NO _____

The program has written plans for the admission, care, treatment and discharge of all clients.

YES _____ NO _____

Indicate which of the following services and programs are provided in the care of clients.

_____ (i) A counseling staff available to provide evaluation, counseling, and referral.

_____ (ii) Recreation and rehabilitation activities geared for therapeutic purposes and under the guidance of program staff.

b. Documentation of a sliding fee scale for clients, based on ability to pay.

YES _____ NO _____

c. Documentation of a formal admission procedure, treatment plan, and evidence of client participation.

YES _____ NO _____

d. Present a current individualized treatment plan.

In Compliance _____ Non-Compliant _____

e. Staff includes:

(i) A house manager.

YES _____ NO _____

(ii) A minimum of one staff member for admitting, treating, and discharging.

YES _____ NO _____

How many? _____

11. Outpatient Treatment Component

a. Does the program provide alcoholism counseling services to those in need, and possess an active outreach philosophy?

YES _____ NO _____

b. Program

Indicate if the program contains the following services or elements:

_____ Availability of service 24 hours a day, 7 days a week.

_____ A revolving schedule of counselors on call.

_____ Written plans for acceptance to the program, resources available and a procedure for referral.

(i) Does the program include services for appropriate counseling and referral?

YES _____ NO _____

(ii) Review a current individualized treatment plan:

Is it current?

YES _____ NO _____

Does it contain follow-up plans?

YES _____ NO _____

Is it individualized?

YES _____ NO _____

Are the goals and objectives realistic?

YES _____ NO _____

c. Staff

(i) The counseling staff is required to possess the following requirements:

Training in the field of alcoholism counseling and education.

YES _____ NO _____

An ability to work with clients.

YES ____ NO ____

A knowledge of the etiology of alcoholism.

YES _____ NO _____

(ii) Is there sufficient staff to provide 24 hour on call service?

YES _____ NO _____

(iii) Does the staff demonstrate a familiarity with community resources, specifically referral?

YES _____ NO _____

(iv) Is continuing education made available for staff?

YES _____ NO _____

MONTANA STATE PLAN FY 76

ESSENTIAL COMPONENTS OF A COMPREHENSIVE SERVICE/TREATMENT SYSTEM

FOR THE ALCOHOLIC OR PROBLEM DRINKER

These are closely related to the essential services needed by Mental Health Centers in order to provide a continuum of care for patients.

In-Patient Services. This generally refers to residential treatment at an institution such as is available at Galen. It also refers to short-term in-patient treatment sometimes provided in a local hospital.

24-Hour Emergency Services. This usually refers to detoxification of the acutely ill alcoholic who will require some medical attention for his symptoms. Such services are most often given in a hospital setting, however, paramedical detoxification centers affiliated with hospitals but physically apart from them are currently being used with great success in detoxification and, most importantly, for short-term treatment of the alcoholic. Lower cost of these facilities is a decided advantage over hospitalization. Where hospitals are used for this care, it is essential that a service system be available to the patient for followup treatment.

Out-Patient Services. These services refer to the earlier detection, diagnosis and treatment, and followup of individuals with symptoms of alcoholism. This component may actually consist of several different agencies or people organized to provide the functions stated above on behalf of the alcoholic and family memebers. Out-patient services such as counseling of family members may result in earlier detection of the

disease. Alcoholics Anonymous is also an example of an out-patient service and fulfills the followup function and, for many alcoholics, a treatment function. In order to fully meet the criteria for an out-patient component by National Institute on Alcohol Abuse and Alcoholism standards, there must be a professional component to the out-patient services. Hence, AA and the AA family groups are seen by this agency more as support services than as diagnosis and treatment services.

Intermediate Care. This component refers to care rendered the patient following detoxification and diagnosis. It may take place in several settings. It may occur immediately following hospitalization for acute alcoholism and focus on those individuals who are too ill to return immediately to homes but who do not require residential treatment or it may mean care in a halfway house setting following residential treatment for patients who need help in readjusting to a community. Ideally, Intermediate care services currently available in our state are halfway houses set up to provide care once a patient has been through residential treatment. In its truest sense, this type of care should be available to circumvent the need by patients for expensive residential care.

Prevention - Education. These two components are not necessarily synonymous. Prevention has three parts: (1) Primary--programs aimed at that portion of the population which is not necessarily presumed to currently have problems with alcohol but who may be prevented from

ever experiencing them; (2) Secondary--programs designed to treat the problem at an earlier stage (i.e., detecting problem drinkers who are in the early stages of the disease); and (3) Tertiary--programs for treating alcoholics in the advanced stages of the disease and raising their level of functioning with a goal of total recovery. The current national target for prevention programs is to be found in primary prevention programs (i.e., programs aimed at pre-school populations and early elementary age groups; education of parents about parenting is another example of primary prevention programming).

The education portion of this service refers to educating the community at large beginning with basic facts concerning the disease of alcoholism and its detection to the effects of alcohol on the body, drinking patterns, etc. Unlike prevention programs, education generally refers to specific information being given about alcohol or alcoholism. Prevention programs may deal with human needs, communication, etc., without becoming specific about alcohol or alcoholism but focusing on imporving people's relationships as one deterrent to alcoholism.

An additional education function is to provide training and/or education to providers of services, generally professional persons involved in the delivery of care to alcoholics but not excluding mental health workers and medical personnel. Education of others such as clergy and school personnel is also appropriate to raise

the level of understanding of the alcohol problem and, it is hoped, to aid in earlier detection and diagnosis.

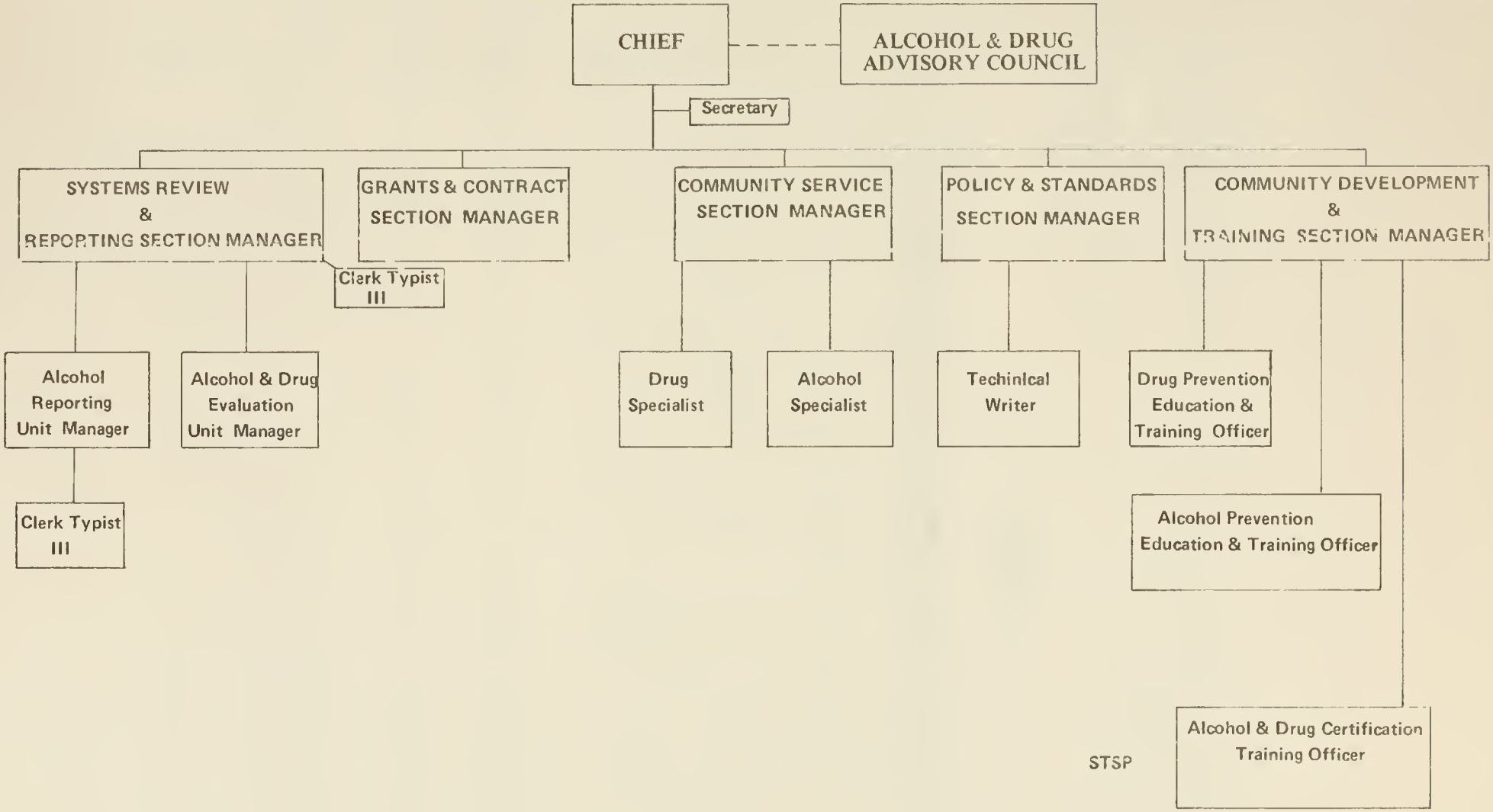
While our solutions to the alcohol problem in Montana may need to be unique and of our own design, the needs of the alcoholic for care are rather universal. It is out of this general universality of need by people afflicted with the problem that these standards and care system have been identified. How we establish our comprehensive treatment system and who fulfills each of the functions must be our decision and our implementation.

SECTION 9

9.1 DEPARTMENT OF INSTITUTIONS ORGANIZATION CHART

9.2 BUREAU OF ADDICTIVE DISEASES ORGANIZATION CHART

ADDICTIVE DISEASES BUREAU



SECTION 10

10.1 JOB DESCRIPTIONS FOR STAFF BUREAU OF ADDICTIVE DISEASES

REGIONAL ADDICTIVE DISEASES RESOURCE DEVELOPMENT SPECIALIST

Description of Work

GENERAL DUTIES: Performs coordinative and developmental functions relative to the delivery of substance abuse services in Montana Mental Health Regions. Authorizes reimbursements to approved alcohol programs for delivery of specific alcoholism funds.

SUPERVISION: Works under the general guidance and direction of Regional Mental Health Boards.

Example of Duties

Responsible for development of programs in accordance with existing laws. Surveys the Region identifying existing resources and services, potential resources and persons. Establish a work plan for conversion of potential into active resources. The plan must include specific goals and objectives specifying numbers, places, times, and product. Identify strategy to be used in the development of programs and services. Develop training programs to involve the allied social and health professionals to integrate them into the substance abuse (alcoholism) service delivery system. Hold public meetings to coordinate the activities in the region and assure citizen input to the regional alcohol plan. Write, in cooperation with alcoholism programs and other agencies, an annual plan for delivery of alcoholism services. Develop and coordinate education and prevention resources in the Region. Serve as a facilitator of client entrance into the Regional alcolism service delivery network.

QUALIFICATIONS: A good basic knowledge of substance abuse, community organization and development, program administration. A working knowledge of public relations and public information techniques.

ABILITIES: Above average ability in all areas of communication both written and verbal. Ability to motivate self and others to accomplish commonly agreed goals.

EDUCATION & EXPERIENCE: Bachelor's Degree from a four year accredited college or university plus four years of progressively responsible experience which demonstrates capability for successful organization and development of programs, or any equivalent combination of training and/or experience.

Salary range - $15,722 - $17,256 (Grade 15 or 16)

SECTION 11

11.1 PROPOSAL TO CSTAA FOR FUNDS TO IMPLEMENT EVALUATION COMPONENT

11.2 COPY OF DATA COLLECTION CURRENTLY BEING USED

The enclosed proposal to the Council of State and Territorial Alcoholism Authorities for an evaluation grant has been approved for funding. The funding period will be from July 1, 1976 through June 30, 1977.

State of Montana

Department of Institutions

GOVERNOR
THOMAS L. JUDGE

DIRECTOR
ROBERT H. MATTSON

BOARD MEMBERS
ZELLA A. JACOBSON, C. FAT FALLS
ELDON E. KUHNS, BILLINGS
WILLIS M. McKEON, MALTA
ROBERT J. PALLO, KALISPELL
JOHN W. STRIZICH, M.D., HELENA

Helena, 59601

January 6, 1976

MONTANA STATE PLAN FY 76

Thomas E. Price, Ph.D., Executive Director
Council of State and Territorial Alcoholism Authorities
Suite 206
1101 15th Street N.W.
Washington, D. C. 20005

Dear Sir:

Enclosed for your acceptance is a contract proposal in response to RFP CSTAA 75-02. All pricing and work program data is firm and will remain so for at least one hundred twenty (120) days from your date of receipt.

The Department of Institutions, Addictive Diseases Division agrees to abide by and comply with all requirements as set forth in the proposal.

Hopefully, the proposal is complete and will meet with your approval. Do not hesitate to call if you need additional information.

Sincerely,

Robert H. Mattson

Robert Mattson, Ed.D.
Director
Department of Institutions

MONTANA STATE PLAN FY 76

MONTANA RFP CSTAA 75-02 SUMMARY

This project proposal is being submitted by the Addictive Disease Division (ADD) on behalf of the Montana State Alcoholism Authority. ADD consolidates both alcoholism and other drug abuse State Office functions in the Department of Institutions. Internal reorganization is continuing to more clearly delineate staffing patterns and organizational roles within the newly created Division. It is certain, however, the alcoholism and other drug abuse State Agencies will be units of equal status under the single administration of ADD.

Since the development of Management Information System (MIS) is already part of the State Plans for both Alcoholism and Drug Abuse, State resources and staff time have already been dedicated to this effort. Participation in the CSTAA program is viewed as an access to groundwork already accomplished, as well as an offering of experience in ultra-rural planning dealing with Native American minorities.

The first project year would complete two phases, Needs Assessment and System Design, in the belief that CSTAA expertise would be most valuable in these phases. Needs would be determined in two stages: the first a preliminary survey to develop working forms and technique, and the second involving a personal, more detailed interview. A full time Program Manager, who will do extensive traveling to conduct interviews and needs assessment, and a Secretary, will be required to complete the project. Two present-staff within the ADD would also assist in the project (See In-kind Services Form) on a part-time basis. An analysis and final report prepared by the Program Manager would complete the

Needs Assessment Phase.

System Design, the second CSTAA Phase, would be accomplished through collaboration between State staff, Program Manager, CSTAA and pilot project areas. A tentative design acceptable to pilots and ADD for implementation of "in-service development" projects in the second project year would signal completion of the Design Phase and of the first project year.

Distinctive features of the Montana Proposal are a concerted effort to include minority recommendations, "in-service development, ultrarural perspective," and comprehensive planning which incorporates federal, state and local program persepctives. Though capability presently exists within Montana State Government to mechnically process all acquired data, funding levels do not permit utilization of these resources. Initially manual processes will be developed which may be reaily computerized when funding becomes available.

The proposed project is expected to begin in July, 1976, and to run for a full year, with completion of Phase 1 and release of a Needs Analysis Report scheduled for January 1977, and completion of Phase 2 and funding of pilot projects expected in June 1977. Project could be started at an earlier date should funding become available.

Alcoholism program management information is often forwarded directly to the Federal Agency involved. The Montana Proposal names the ADD, via the State Alcohol Authority as reporting intermediary for all federally funded alcoholism programs in Montana. The Integrated Drug Abuse Reporting Process (IDARP) which has been initiated by the Drug

Abuse State Agency should provide a good basis for coordination within ADD. The process presently collects client oriented data through Client Oriented Data Acquisition Process (CODAP), program data through the Drug Abuse Program Resource Unit (DAPRU) and is studying the feasibility of establishing a Financial Management Information System (FMIS). Mental Health Programs presently have a fully automated client oriented data system with information collected at admission and termiantion. Data from veterans hospitals and private programs is not presently available.

The CSTAA proposed data elements upon preliminary survey appear to be very compatible with present intents, though the material collected may be altered either in the Design Phase or during in-service development.

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Montana, geographically the fourth largest state in the union, is also one of the nation's least populated states. Montana has less than a dozen communities with a population density of 20,000 or more people. Montana borders three rural Canadian provinces on the North, the Dakotas to the East, Wyoming to the South and Idaho to the west.

In recent years, workers in the social service fields have observed an alarming increase in both use and abuse of alcohol in Montana. This has created an ever increasing need for alcohol service programs within the State and also the need for a standard management information system to monitor and evaluate these services.

In Montana, the State Alcohol Authority and the State Drug Authority share the same State Advisory Council. Alcohol Services Division was transferred by legislative action from the State Department of Health and Environmental Sciences to the Department of Institutions as of July 1, 1975. The same act also transferred the Addictive Diseases Unit and the Office of the Drug Coordinator from the Governor's Office, to unite alcohol and drug authorization in a single administrative unit called the Addictive Diseases Division. This reorganization was undertaken to correct a growing fragmentation of State level responsibilities for alcohol planning and service delivery as well as to respond to local regional requests for closer coordination and control of alcohol and drug program efforts.

The Addictive Diseases Division is now ready to fully commit itself to development and implementation of a Management Information System for alcohol service programs, which will meet Federal, State and local

needs. At the present time the Addictive Diseases Division is not funded or staffed to develop such a system. With funds and assistance requested by this proposal, the needs assessment and system design would be completed, assuring a State commitment for continuing development and implementation.

MONTANA STATE PLAN FY 76

STATUS REPORT

Montana has nineteen Alcohol Service delivery programs, many of which receive mixed funding from Federal, State and local sources. Each funding source has separate data reporting requirements, and as a result, there is duplication of effort at the local level. At the present time, the Montana SAA has a simplified client data collection form (Appendix A). This monthly form is being filled out by each alcohol service program with the exception of the State-operated treatment program.

Montana Alcohol Services Programs submit fiscal information to individual funding sources. Programs funded through the State Alcohol Authority (twelve of the nineteen report actual expenditures on forms 1010 and 1020 (Appendix B-C). Indian programs provide fiscal reports to both NIAAA and the Indian Health Service. One program has an NIAAA staffing grant which provides fiscal information through the Stanford Research Institute reporting system.

Problems or Gaps in State MIS Systems

1. Duplication of effort at the local level.

Because of mixed funding, alcohol programs are often required to submit management information reports to different funding sources.

2. Data is being gathered, but not used.

Although the SAA has a simplified client data collection system,

the data is being collected and filed, but not being processed or analyzed due to lack of funds and manpower.

3. Incomplete and poor response to present State data collection system.

Although all Alcohol Service Programs are required to complete the State monthly client data collection form, those seven programs not receiving State funds or funds through the SAA usually do not complete the form.

4. Programs receive no informational return from State forms they submit.

Since the data is not being processed or analyzed at the State level, local programs are not encouraged by receiving any type of client information return.

5. Inadequate data.

Data presently collected provides no individual client perspective for State or local levels.

6. No State level information center exists to completely monitor all alcohol service programs within Montana.

As long as Alcoholism reporting is completely dependent on funding sources, the SAA is unable to completely monitor total alcohol service programs within the State.

MONTANA STATE PLAN FY 76

Existing State MIS Resources

In addition to information collected by the Alcoholism SSA, the Addictive Diseases Division also collects drug abuse information through the NIDA funded IDARP contract with utilizes CODAP to gather client data, DAPRU for inventory and resource data and FMIS for financial data. Through relocation in the Addictive Diseases Division, the State Alcohol Authority has gained access to established working relationships with the Department of Institutions, Data Information Bureau, which presently processes management information for Mental Health Services. The State Department of Administration, Data Processing Bureau, and the Montana University System maintain extensive equipment and staff expertise which can be relied upon as additional resources for MIS development.

Current Plans (Pre CSTAA)

Current plans for further development of MIS for Montana Alcohol Programs are limited, by lack of staff and involve upgrading the present form being used and developing staff ability to porcess and analyze collected data regularly.

Participation in the above upgraded system is perceived as an eventual prerequisite for alcohol program accreditation by the State. Further simplification of present procedures as well as improved analysis procedures and increased feedback to participating programs are expected to encourage and improve local response.

MONTANA STATE PLAN FY 76

BRIEF DESCRIPTION OF PROJECT GOALS

The first project year (with which this proposal deals) will consist of two phases: First, needs assessment to determine local, State and Federal needs for alcohol MIS, and second, system design which will be coordinated with pilot programs and will utilize CSTAA assistance.

Goals

1. Needs Assessment Goal: Determine Federal, State and local MIS needs.

   Objective A. Determine local alcohol program needs.

   Objective B. Determine SAA and other state agency needs.

   Objective C. Determine Federal needs.

   Objective D. Determine specific Indian and other minority needs.

   Objective E. Compile final report.

2. System Design Goal: Incorporate Federal, State and local needs into tentative MIS design based on determined needs.

   A. Determine specific data elements.

   B. Design mechanical system components.

   C. Coordinate system design with programs.

   D. Compile initial system design in report form.

Second year project activity will cover the remaining three CSTAA MIS development phases: final development, full implementation and

system evaluation. After the first quarter of the second project year, information garnered from ongoing pilot projects will be utilized for final development during the second and third quarters. Total implementation would be initiated in the fourth quarter, with a first evaluation report due at the end of the second project year.

MONTANA STATE PLAN FY 76

COMMITMENT OF SAA TO DEVELOP AN ON-GOING SYSTEM

The Montana Addictive Diseases Division (SSA-SAA) believes that the quality of decisions made by management are directly related to the quality and quantity of data available to support those decisions. To keep the doors of future alcohol service programs open, the Division must show that all conditions of Federal and State contracts have been satisfied. Programs must demonstrate to the Division, and subsequently to the State Legislature, that an adequate level of service if being provided. The only effective way to assure this is to develop an ongoing MIS to effectively monitor and evaluate programs. The need for effective program monitoring and evaluation is frequently voiced and endorsed by local programs, the SAA, the State Legislature and NIAAA. Further phase development beyond this RFP will certainly command State support, since MIS development is an expressly stated objective in the approved State Plans submitted by both alcoholism and drug abuse authorities.

MONTANA STATE PLAN FY 76

APPROACH

Understanding the Problems

Unfortunately, a majority of management information systems designed to collect social service data at Federal, State and local levels are designed and developed with the data needs of only one organizational level in mind. Alcohol Service plans run the risk of providing inappropriate or unusable services if these services are planned and designed without coordinated attention to needs at Federal, State and local levels. A thorough assessment and investigation of all needs must be accomplished to create an information system that is meaningful and useful to service providers who devote scarce staff time and other program resources to participation.

Present efforts to collect management information, while they needlessly burden local staff and are not closely analyzed by State staff, have formalized both the concept and the associated communication channels necessary for MIS development. Coordination of MIS development with the Drug Information System (IDARP) and other systems being planned by the Addictive Diseases Division will be a key planning concern. While local and state needs must be severed, data products must be compatible with national requirements and CSTAA goals.

Technical Approach

A first year plan involving the first two phases of CSTAA's five phase development is presented covering needs assessment and MIS design. Efforts will be made to take full advantage of any prior CSTAA developmental work which relates to rural settings and to the needs of Indian minorities. Where prior development is inadequate, the Montana Plan will initiate necessary research and development to produce practical and workable instruments and approaches. Central to success of the plan is increased staffing to conduct accurate and comprehensive needs assessment. Travel to nineteen program sites across the nation's fourth largest state to conduct in-person assessment is perceived as inevitable and necessary. Past efforts utilizing detailed mail-out forms have met with poor response.

It is anticipated that MIS design will be facilitated by technical assistance from CSTAA and by knowledge and experience gained from other states involved in MIS development. However, it is recognized that final development and implementation will be governed by combined needs of Federal, State and local alcohol authorities, the availability of on-going State funding and staff, and the cooperation of local programs.

Evaluation methods and criteria used by the State Alcohol Authority will be coordinated with MIS design and development and will be reflected in the detailed evaluation section of the State work program. Input from evaluated programs will be used to modify techniques and expand

MONTANA
ADDICTIVE DISEASES DIVISION
RFP CSTAA 75-02
WORK PLAN

PHASE I Needs Assessment — DATE July 1976-Dec. 1976

TASK	CALENDAR TIME	PERSON DAYS	PRODUCT	TECHNICAL ASSISTANCE
Objective A. Local Needs Assessment				
Task 1. Inform all programs of needs assessment for MIS	July 9, 76	5	Informed Programs	
2. Set up meeting with programs concerning MIS	July 16	2		
3. Conduct meetings with prog.	July 30	1	Prog. input	
4. Contact CSTAA for information or assistance concerning local program needs assessment	July 16	7	Info from CSTAA	CSTAA - other States
5. Develop standardized assessment procedures, instruments & interview techniques for needs assessment	Aug. 13	10	Assessmt. Tech. instr. developed	CSTAA - other States
6. Consider & determine unique problems of Indian and Reservation Alcohol prog.	Aug. 6	5	Indian Problems	
7. Conduct onsite needs assessment of all prog. concerning MIS	Nov. 26	50	Local needs gathered	
8. Evaluate & analyze data & consolidate similar needs	Dec. 17	3	consolidate needs	CSTAA
9. Develop final report on local needs	Dec. 31	2	Report of local needs	CSTAA
Objective B. State Needs Assessment				
Task 1. Conduct survey of SAA to determine State needs for client data, funding data, & prog. evaluation data.	July 30	3	State needs	
2. Contact CSTAA for assistance	Aug. 6	2	Additional needs input	CSTAA
3. Contact other states similar to Mont. for MIS needs	Oct. 8	2	Additional Input	
4. Determine specific State needs concerning Indian or other minority programs	Sept. 10	2	Indian needs	

MONTANA
ADDICTIVE DISEASES DIVISION
RFP CSTAA 75-02
WORK PLAN

PHASE I Needs Assessment — DATE 7/1/76 - 12/31/76

TASK	CALENDAR TIME	PERSON DAYS	PRODUCT	TECHNICAL ASSISTANCE
Objective B. (continued)				
Task 5. Process & analyze State needs	Nov. 12	4	Consolidate needs	
6. Develop final report	Dec. 17	2	State needs	CSTAA
Objective C. Determine Indian Needs				
Task 1. Conduct needs assessment surveys with all Indian & Reservation Alcohol Prog.	Nov. 26	14	Indian needs	
2. Contact CSTAA for information concerning other Indian needs	Aug. 6	2	Additional needs	CSTAA
3. Contact other states for Indian MIS info. needs	Oct. 8	2	Additional needs	
4. Meet with Mont. Indian Comm. on Alcohol & Drugs for input	Aug. 6	2	Info. & Input	
5. Contact & meet with Indian Health Services	Oct. 29	2	Indian Hlth. Serv. Data	
6. Develop final recommendations	Nov. 31	3	Indian needs	CSTAA
Objective D. Determine Federal Needs & Requirements				
Task 1. Contact NIAAA, Office of Prog. Development & Analys. concerning Federal Data Coll. & Monitoring needs	Aug. 13	2	NIAAA data collection requirements	NIAAA
2. Contact CSTAA for info. & assistance	Aug. 6	2	Additional info. & assistance	CSTAA
3. Determine & analyze Federal funding criteria for Alcohol service providers	Sept. 17	1	Federal funding criteria	NIAAA
4. Determine unique Federal requirements for Indian program	Oct. 8	2	Unique Indian requirements	NIAAA

MONTANA
ADDICTIVE DISEASES DIVISION
RFP CSTAA 75-02
WORK PLAN

PHASE I Needs Assessment DATE 7/1/76-12/31/76

TASK	CALENDAR TIME	PERSON DAYS	PRODUCT	TECHNICAL ASSISTANCE
Objective D. (continued)				
Task 5. Determine SAPIS reporting requirements	July 31	1	SAPIC reporting requirements	CSTAA-NIAAA
6. Develop final report	Dec. 3	2	Federal needs	
Objective E.				
Develop final report establishing all Federal, State and Local needs concerning MIS for Alcohol Service Program	Jan.7, 1977	5	Final needs report	CSTAA

MONTANA
ADDICTIVE DISEASES DIVISION
RFP CSTAA 75-02
WORK PLAN

PHASE II System Design — DATE Jan. 1977 - June 1977

TASK	CALENDAR TIME	PERSON DAYS	PRODUCT	TECHNICAL ASSISTANCE
Objective A. Determine Data Elements				
Task 1. Confer with CSTAA, concerning data elements	Jan. 21	5	information assistance	CSTAA
2. Consult with other states	Jan. 21	2	Info.	CSTAA
3. Meet with data processing consultant	Jan. 28	3	System Input	State CSTAA
4. Determine data elements design from need assessments	Jan. 31	7	Data elem.	CSTAA
Objective B. Design Mechanical System				
Task 1. Consult with CSTAA overall System Design (manual-automatic)	Feb. 11	3	Design Assistance	CSTAA
2. Design Input forms and/or Instruments	Feb. 25	7	Input forms	State CSTAA
3. Consult with Data Processing concerning system design for eventual automation	Feb. 3	3	DP System Development	State CSTAA
4. Design System Flow procedures & Report Routing	Mar. 4	6	Flowchart report procedure	CSTAA
5. Design manual output & information reports to programs	Mar. 18	7	Output rpt.	CSTAA
6. Design reports for Federal & State levels	Mar. 25	7	Info. rpt.	CSTAA
7. Design manuals and other required instruments	Mar. 31	10	Manual Instruments	CSTAA
8. Design training mechanisms & responsibilities	Apr. 8	10	Training procedure	CSTAA
Objective C. Coordinate Systems Design with Local Programs				
Task 1. Conduct informational meetings with all local programs to explain design	Apr. 15	5	Inform Programs	
2. Resolve problem areas	Apr. 22	5	Resolve prob.	

MONTANA
ADDICTIVE DISEASES DIVISION
RFP CSTAA 75-02
WORK PLAN

PHASE II System Design — DATE Jan. 1977 - June 1977

TASK	CALENDAR TIME	PERSON DAYS	PRODUCT	TECHNICAL ASSISTANCE
Objective C. (continued)				
Task 8. Design changes with problem resolutions	May 6	10	Design changes	
Objective D. Complete Final System Design				
Task 1. Determine staffing requirements	May 13	5	Staff req.	CSTAA
2. Determine Costs	May 20	5	Costs	CSTAA
3. Insure compatability with Local, State & Federal requirements	June 3	10	Compatibility	CSTAA
4. Complete final design for pilot	June 24	15	Final Design	CSTAA

areas of greatest need and best effect. Greatest emphasis will be placed on those methods which can be shown to be most effective in rural settings and which are best able to deal with the culturally different treatment modalities and program designs required for Native Americans.

Unique and Innovative Aspects of Approach

The Montana proposal incorporates several unique features, including 3-way design and development, ultra-rural perspective, sensitivity to programs designed to meet culturally different needs of Indians and in-service development.

3-Way Development

Coordinates Federal, State and local needs perspectives at all stages of design, development and implementaion.

Ultra-rural Perspective

Maintains relevancy to the needs of programs separated from each other and the SAA by hundreds of miles of little settled territory, and hampered by little developed public health services and minimal staffing levels.

Sensitivity to Indian Needs

In the wake of increasing enforcement of health facility regulations, many of Montana's sorely needed hospitals and nursing homes have closed because of inability to economically renovate facilities. Indians have been strongly affected by many of these changes and often react negatively to proposed regulations which might restrict service delivery or force programs designed with culturally unique treatment modalities for Indians to conform to non-Indian standards.

In-service Development

The SAA maintains that the scope of useful and practical information can be determined best under working conditions. For this reason, an in-service developmental phase is proposed to test the tentative MIS design in pilot situations and to incorporate findings in final development and implementation stages.

MANAGEMENT PLAN

MONTANA STATE PLAN FY 76

MANAGEMENT PLAN

The proposed MIS project would be administered by the System Review and Reporting Unit (SRRU) of the Addictive Diseases Division, (presently conducting the NIDA IDARP project), with the SRRU Chief directly responsible.

Two full time SRRU positions would be created by the project, Program Manager and Secretary. Though reorganization is still in progress, and staff roles and responsibilities are still in flux, the SRRU will be the administrative responsibility of the Addictive Diseases Division Director. The Program Manager will be solely responsible for conducting on-site assessments, preparing MIS project reports and coordinating local, State and Federal need perspectives, while the State Alcohol Authority and the SRRU Chief will each devote the time necessary (approximately 500 hours) to the project. The SAA will be most involved with the needs assessment phase, coordinating pilot projects and implementation of the final MIS. The SRRU Chief will be closely involved with the design and development, and will coordinate the activities involving CSTAA consultants, State staff (including departmental data processing staff for about eighty hours during the first project year), local project staff and minority representatives. The SRRU Chief will be responsible for any necessary subcontracts or additional consultant services needed.

Key Personnel

Addictive Diseases Division Administrator - Responsible for the

direction, leadership and coordination of all drug and alcohol services within the State of Montana (Michael Murray, Appendix D).

State Alcohol Authority - Responsible for the coordination of alcohol service programs within the State of Montana. (Paul Babbitt, Appendix E).

Systems Review and Reporting Unit - Responsible for the design, development, and coordination and management of Reporting and Evaluation Systems for Alcohol and Drug Services Delivery Programs (Robert Anderson, Appendix F).

Program Manager (CSTAA Proposal) - Responsible for carrying out and completing the goals, objectives and tasks within the CSTAA contract. Vacant position (State Job Description, Appendix G).

Secretary - Responsible for clerical and office duties required by the CSTAA proposal. Vacant position (State Job Description, Appendix H).

Management of Consultants

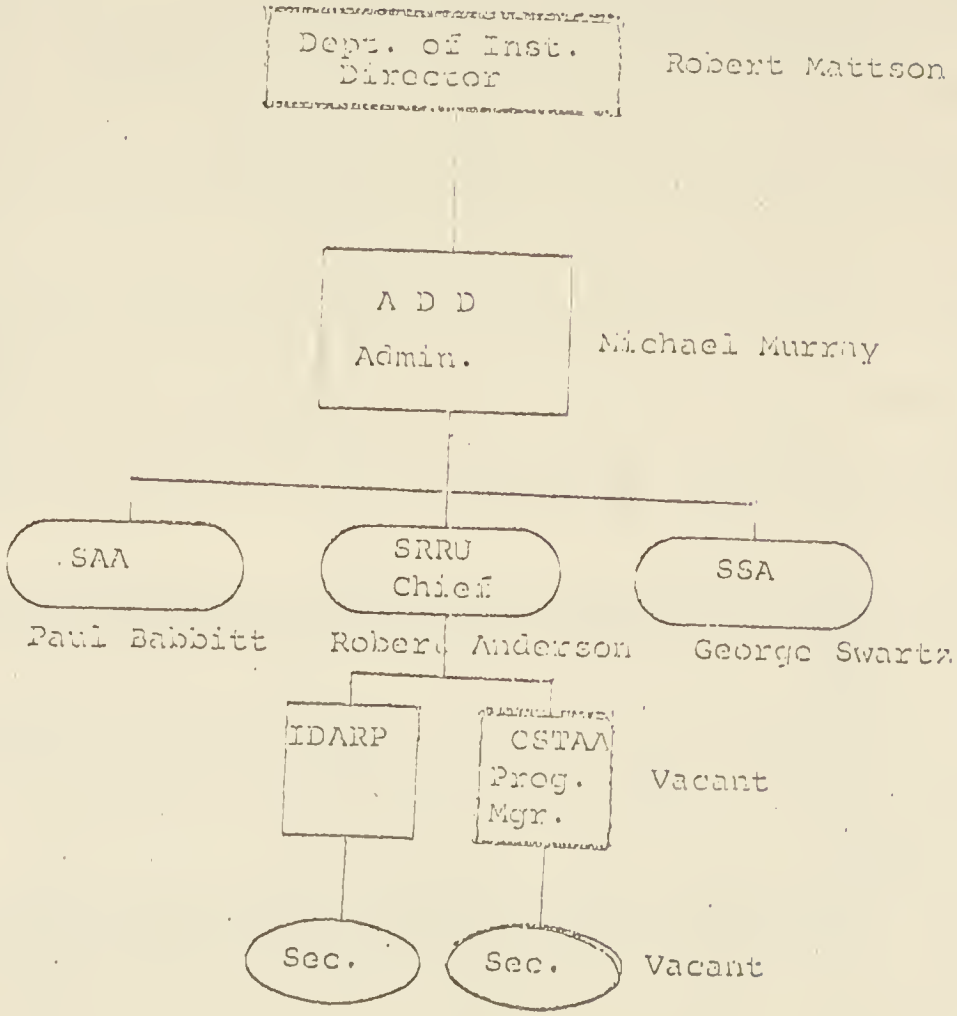
Consultants for this project will be used as deemed necessary by the Program Director and SRRU Chief with prior approval by CSTAA. Contracts for consultants will be written with specific goals, objectives and tasks outlined sufficiently to insure successful job completion and will be monitored by Program Manager and SRRU Chief.

Reports to CSTAA

The Program Manager will be responsible to submit to CSTAA monthly reports describing work completed and expenditures encumbered for each month during the contract period. These reports will be submitted by the 10th day of each month following the report month. First report due August 10, 1976 for the month of July, 1976.

Any additional information or reports would be supplied to CSTAA upon request.

ORGANIZATIONAL CHART



RFP CSTAA 75-02

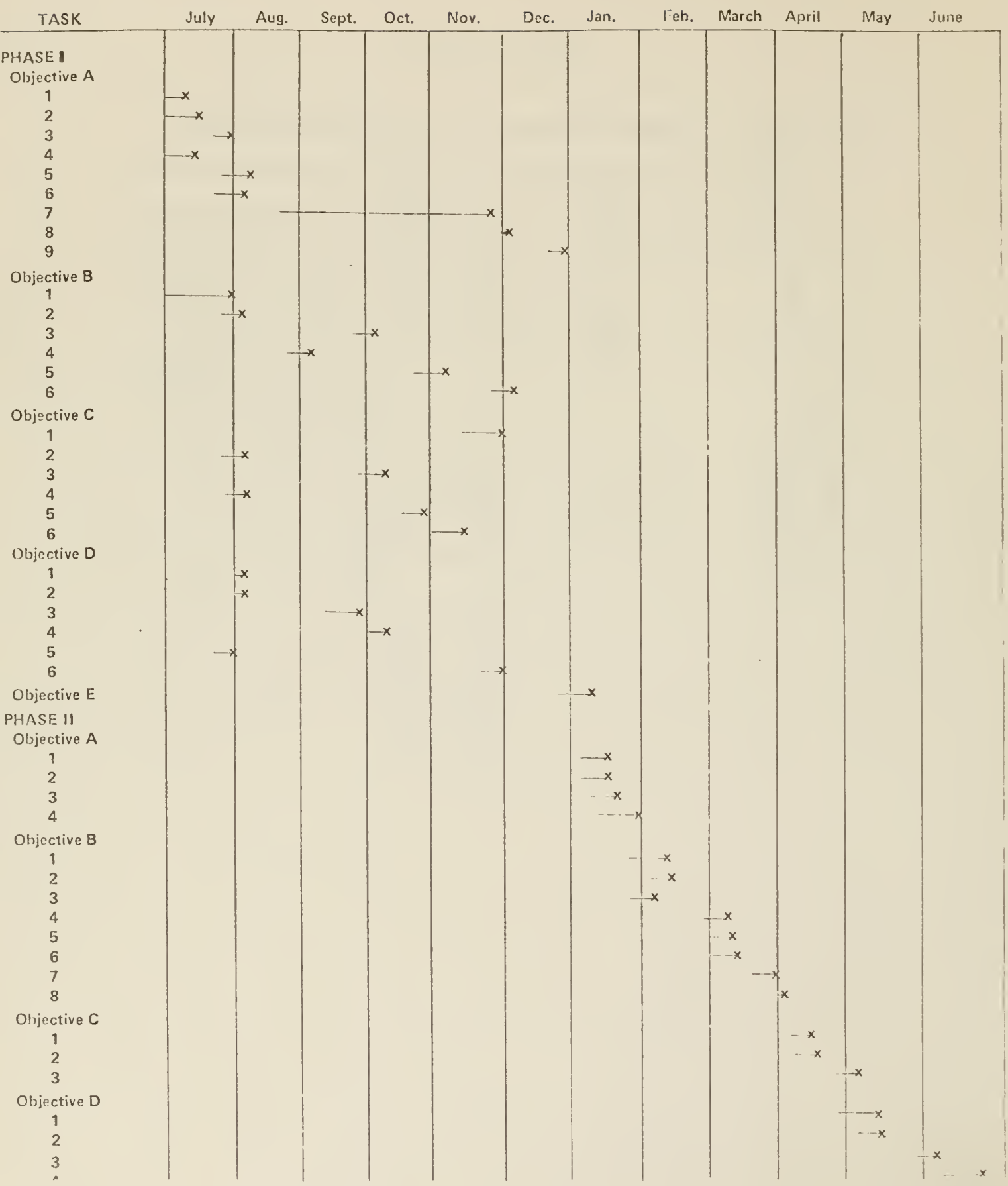
Work Schedule

System Design

Montana

Addictive Disease Division

July 76 - June 77



MONTHLY DATA REPORT

Agency Reporting _____ Date submitted _____ Period _____ to _____

Types of services your agency provides:

Counseling

- Individual ____
- Marital ____
- Family ____
- Group ____

Intermediate care ____

Follow-up ____

Education ____

Outreach ____

Referral ____

Other _____

	Current Month		Total Since July 1	
I.	Male	Female	Male	Female
Number of new clients this month.....				
Number of new residents this month.....				
Number of repeaters this month.....				
Number of residents leaving this month.....				
A. Reason for leaving				
1. Completed program.....				
2. Referred.....				
3. Left without completing program.....				
II.				
Number of clients at following income levels: (New and Repeaters)				
0 - $3600				
$3601 - $8500				
$8500 + ...				
Number of residents at following income levels (New and Repeaters)				
0 - $3600				
$3600 - $8500				
$8500 + ...				
III.				
Number of clients this month				
employed.....				
unemployed.....				
retired.....				

(Definitions on back sheet)

	Current Month		Since July 1	
	Male	Female	Male	Female
Number of residents this month (New and Repeaters)				
employed.....				
unemployed.....				
retired.....				
IV. (Include New and Repeaters) Number of carryover clients this month.....				
Number of carryover residents this month.....				
Number of residents approved for Voc. Rehab.				
How residents and clients will pay for services				
Own funds,.....				
Voc. Rehab.				
General Assistance.....				
No funds to pay.....				
Other (specify).....				
V. Number of clients and residents referred from source (Do not include repeaters)				
A. Law Enforcement.....				
B. Social service agency.....				
C. Voc. Rehab.				
D. Galen.....				
E. Self.....				
F. Other (specify).....				
VI. Number of clients receiving follow-up services (New and Repeaters)				
1. Referred from treatment centers to your program.....				
2. Residents completing your program and now receiving services on an outreach basis.....				

	Current Month		Total Since July 1	
	Male	Female	Male	Female
Repeaters referral source				
A. Law enforcement.....				
B. Social Service Agency.....				
C. Voc. Rehab.				
D. Galen.....				
E. Self.....				
F. Other (specify).....				
VII Age level of clients (New and Repeaters)				
10-20.....				
21-30.....				
31-60.....				
60 + ...				
Age level of residents				
10-20.....				
21-30.....				
31-60.....				
60 + ...				
VIII. How many clients, residents, or both have received previous treatment for alcoholism? (include new and repeaters).....				
On more than one occasion?				
IX. Number of individual counseling (hours).....				
Number of group therapy sessions (hours).....				

150

X.	Current Month		Total Since July 1	
	Male	Female	Male	Female
Number of clients referred to other programs (New and Repeaters)				
Referred where? A. Galen.....				
B. Hospital.....				
C. Other (specify).....				
Number of residents referred to other programs (New and Repeaters)				
A. Galen.....				
B. Hospital.....				
C. Other (specify).....				

XI. EDUCATION	Current Month	Since July 1
1. Number of speeches given.....		
Estimated total audience.....		
2. Number of radio programs.....		
Estimated total audience.....		
3. Number of T.V. programs.....		
Estimated total audience.....		
4. Number of inservice training sessions.....		
5. Pieces of literature distributed.....		
6. Number of films shown.....		
Estimated total audience.....		
7. Number of schools, conferences, etc.		
Attended by staff.....		
Number of staff attending.....		

Date

Authorized Signature

DEFINITIONS

New Client

Refers to individuals you are working with for the first time on an outpatient basis.

Client

Refers to individuals you are providing services to on an outpatient basis (both new and repeaters).

New Residents

Refers to individuals entering your program and "living in" for the first time.

Residents

Individuals receiving services and "live in" (both new and repeaters).

Repeaters

Individuals who have received counseling and/or previous treatment for alcoholism.

Carry-over Client

Refers to individuals you were working with last month and are continuing to work with this month.

Carry-over Resident

Refers to individuals that were "living in" last month and are still "living in" this month.

Follow-up

A. Individuals referred from treatment centers to your program for aftercare counseling and/or intermediate care.

B. Individuals completing your program as a "resident" (live in) and now receiving services on an outreach basis.

SECTION 12

12.1 MONTANA PROPOSAL FOR UNIFORM ACT INCENTIVE GRANT

12.2 AMENDMENTS TO PROPOSAL

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE

OMB NO. 68-R0379

APPLICATION FOR FEDERAL ASSISTANCE
(NONCONSTRUCTION PROGRAMS)

PART I

1. State Clearinghouse Identifier

2. Applicant's Application No.

3. Federal Grantor Agency
National Institute of Alcohol Abuse and Alcoholism

Organizational Unit
Grants Management Branch

Administrative Office
Room 16086 Parklawn Bldg.

Street Address – P.O. Box
5600 Fishers Lane

City: Rockville, State: MD Zip Code: 20852

4. Applicant Name
Montana Department of Institutions

Department Division
Adaptive Services Division

Street Address – P.O. Box
1539 11th Ave.

City: Helena, County: Lewis & Clark

State: Montana Zip Code: 59601

5. Descriptive Name of the Project
Special Grant for Implementation of the Uniform Act

6. Federal Catalog No.
NA

7. Federal Funding Requested
$ 120,000

8. Grantee Type
X State, ____ County, ____ City, ____ Other (Specify)

9. Type of Application or Request
X New Grant, ____ Continuation, ____ Supplement, ____ Other Changes (Specify)

10. Type of Assistance
X Grant, ____ Loan, ____ Other (Specify)

11. Population Directly Benefiting from the Project
88,954

13. Length of Project
12 months

12. Congressional District
a. First Congressional District
b. Statewide

14. Beginning Date
September 1, 1976

15. Date of Application
April 6, 1976

16. The applicant certifies that to the best of his knowledge and belief the data in this application are true and correct, and that he will comply with the attached assurances if he receives the grant.

Typed name: L. B. Carlson, Ed.D.

Title: Administrator Adaptive Services

Telephone Number: AREA CODE 406 NUMBER 449-2827 EXT.

Signature of Authorized Representative
L B Carlson

For Federal Use Only

Project Number

5161-1 (PAGE 1)
(Formerly HEW-608T)
10-73

Form Approved
O.M.B. No. 68-R1379

PART II

OMB NO. 83-R0 186

PROJECT APPROVAL INFORMATION

Item 1.
Does this assistance request require State, local, regional, or other priority rating?
____ Yes _X_ No
Name of Governing Body ____
Priority Rating ____

Item 2.
Does this assistance request require State, or local advisory, educational or health clearances?
____ Yes _X_ No
Name of Agency or Board ____
(Attach Documentation)

Item 3.
Does this assistance request require clearinghouse review in accordance with OMB Circular A-95?
_X_ Yes ____ No
(Attach Comments)

Item 4.
Does this assistance request require State, local, regional or other planning approval?
_X_ Yes ____ No
Name of Approving Agency Comprehensive Health Planning "A" Agency
Date ____

Item 5.
Is the proposed project covered by an approved comprehensive plan?
_X_ Yes ____ No
Check one: State [X]
Local [ ]
Regional [ ]
Location of Plan ____

Item 6.
Will the assistance requested serve a Federal installation?
____ Yes _X_ No
Name of Federal Installation ____
Federal Population benefiting from Project ____

Item 7.
Will the assistance requested be on Federal land or installation?
____ Yes _X_ No
Name of Federal Installation ____
Location of Federal Land ____
Percent of Project ____

Item 8.
Will the assistance requested have an impact or effect on the environment?
____ Yes _X_ No
See instructions for additional information to be provided.

Item 9.
Will the assistance requested cause the displacement of individuals, families, businesses, or farms?
____ Yes _X_ No
Number of:
Individuals ____
Families ____
Businesses ____
Farms ____

Item 10.
Is there other related assistance on this project previous, pending, or anticipated?
____ Yes _XX_ No
See instructions for additional information to be provided.

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OMB NO. 68-R0108

PART III – BUDGET INFORMATION

SECTION A – BUDGET SUMMARY

Grant Program, Function or Activity (a)	Federal Catalog No. (b)	Estimated Unobligated Funds		New or Revised Budget		
		Federal (c)	Non-Federal (d)	Federal (e)	Non-Federal (f)	Total (g)
1. Implementation		$	$	$120,000	$	$120,000
2.						
3.						
4.						
5. TOTALS		$	$	$120,000	$	$120,000

SECTION B – BUDGET CATEGORIES

6. Object Class Categories	– Grant Program, Function or Activity				Total
	(1) Implementation		(3)	(4)	(5)
a. Personnel	$26,232	$	$	$	$
b. Fringe Benefits	3,279				
c. Travel	5,000				
d. Equipment	3,200				
e. Supplies	2,000				
f. Contractual	45,589				
g. Construction	–				
h. Other	34,700				
i. Total Direct Charges	120,000				
j. Indirect Charges					
k. TOTALS	$120,000	$	$	$	$
7. Program Income	$	$	$	$	$

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SUPPLEMENTARY INSTRUCTIONS
APPLICABLE TO THE PUBLIC HEALTH SERVICE PROJECT GRANTS

(Part III)

General

Grant programs supported by the PHS do not require a budget breakdown by function or activity.

Sections A thru D should provide budget estimates for 12-month periods unless program guidelines stipulate otherwise.

Research Grant Applications

Cost sharing from non-Federal funds is required on all research projects; however, the level of such cost sharing proposed by the applicant should not be shown in the application. Use the following instructions when applying for a research grant:

1. Section A–Leave columns (d) and (f) blank.
2. Section B Enter the requirements for Federal funds only.
3. Section C–Leave blank.
4. Section D- Complete line 13 only.

SECTION A – BUDGET SUMMARY

Lines 1-4

Columns (c) and (d) - For continuing grant applications only, the estimated unobligated funds should always be entered in these columns.

SECTION B – BUDGET CATEGORIES

Line 6(a) Personnel–Show salaries and wages only. Fees and expenses for Consultants should be included on Line (h) Other. Salary amounts and level of effort must be identified in the supplement to Section F (Page 4a) for each key position identified by name or title in the program narrative.

Line 6(b) Fringe Benefits–Leave blank if fringe benefits applicable to direct salaries and wages are treated as part of indirect costs in the indirect cost rate negotiation agreement.

Line 6(c) Travel–Use only for travel (foreign and domestic) of employees on the grant. Travel of consultants, trainees, etc., should not go on this line, nor should local transportation (i.e., where no out-of-town trip is involved). Any foreign travel requested must be separately identified and justified under Section F.

Line 6(d) Equipment–Use only for nonexpendable personal property, which is defined as follows:

Nonexpendable personal property means tangible personal property having a useful life of more than one year and an acquisition cost of $300 or more per unit. A grantee may use its own definition of nonexpendable personal property provided that such definition would at least include all tangible personal property as defined below.

Personal property means property of any kind except real property. It may be tangible–having physical existence, or intangible–having no physical existence, such as patents, inventions, and copyrights.

Each item of nonexpendable personal property costing over $1000 and each item of General Purpose Equipment costing over $300 must be identified and explained under Section F. (General Purpose Equipment means items such as office equipment, air conditioning and furnishings which are usable for activities other than the technical, specialized aspects of the grant program.)

Line 6(e) Supplies. Include all tangible personal property except that which is on line (d) Equipment. Requests in excess of $500 per category of tangible personal property (supply) must be identified and explained under Section F.

Line 6(f) Contractual–Use for (1) procurement contracts (except those which belong on other lines such as equipment, supplies, and construction), (2) inpatient and outpatient care cost, and (3) contracts or other agreements with secondary recipient organizations such as affiliates, cooperating institutions, delegate agencies, political subdivisions, etc. Line (f) must not include payments to individuals such as stipends and allowances for trainees, consulting fees, benefits, etc. Requests in (1) above in excess of $2,500 and each item in (2) and (3) above must be identified and explained under Section F.

Line 6(g) Construction- Use for both new construction and for alteration and renovation. Most PHS programs using this application do not have construction authority. Check the program guidelines. If new construction is authorized and you are requesting it, you must include with this application Part II, Section B, Part III and the Assurances from the A-102 Construction Application Form PHS 5162-1. Amounts entered for this item must be explained under Section F.

Line 6(h) Other–Use for all direct cost not clearly covered by lines (a) through (g). Examples are animals, computer use charges, consultant cost, drugs, payments to individuals such as stipends and allowances, tuition, space or equipment rental, and local transportation. Requests for any item identified in OMB Circular A-87, Attachment B, Sections B and C, which require approval by the awarding agency must be identified and explained under Section F.

SECTION C – NON-FEDERAL RESOURCES

(a) Grant Program	(b) APPLICANT	(c) STATE	(d) OTHER SOURCES	(e) TOTALS
8. Implementation – Uniform Act	$593,227	$	$225,000	$ 818,227
9.				
10.				
11.				
12. TOTALS	$	$	$	$

SECTION D – FORECASTED CASH NEEDS

	Total for 1st Year	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
13. Federal	$ 120,000	$45,000	$ 25,000	$25,000	$ 25,000
14. Non-Federal	818,227				
15. TOTAL	$ 938,227	$	$	$	$

SECTION E – BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED FOR BALANCE OF THE PROJECT

(a) Grant Program	FUTURE FUNDING PERIODS (YEARS)			
	(b) FIRST	(c) SECOND	(d) THIRD	(e) FOURTH
16. Implementation – Uniform Act	$120,000	$120,000	$ 120,000	$
17.				
18.				
19.				
20. TOTALS	$ 120,000	$ 120,000	$120,000	$

SECTION F – OTHER BUDGET INFORMATION

(Attach additional Sheets If Necessary)

21. Direct Charges:

22. Indirect Charges:

23. Remarks:

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PART IV PROGRAM NARRATIVE (Attach per instruction)

MONTANA STATE PLAN FY 76

SUPPLEMENT TO PART III, SECTION F
KEY PERSONNEL

NAME	ANNUAL SALARY RATE	NO. MOS. BUDG.	% TIME	TOTAL AMOUNT REQUIRED	SOURCE OF FUNDS: APPLICANT AND OTHER	SOURCE OF FUNDS: REQUESTED FROM PHS
	(1)	(2)	(3)	(4)	(5)	(6)
Law Enformcement Specialist	13,116	12	100	13,116		13,116
Treatment Specialist	13,116	12	100	13,116		13,116
FRINGE BENEFITS (Rate 12.5)				3,279		3,279
CATEGORY TOTAL				$29,511	$	$29,511

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MONTANA STATE PLAN FY 76

In Montana, the need exists for the development of comprehensive alcohol programs which can provide a full range of services to the general public. This range of services includes: prevention, outpatient care, intermediate care, inpatient services and emergency care. The means to establish these comprehensive services exists through legislation passed in the 1974 and 1975 Montana Legislative Sessions. The implementation of these laws is vital to the development of adequate care for the alcoholic and alcohol abuser in Montana.

MONTANA STATE PLAN FY 76

PART IV

PROGRAM NARRATIVE

The following narrative consists of documents and information required under Tabs A, B, C, D, and E of the guidelines for Special Grants for Implementation of the Uniform Alcoholism and Intoxication Treatment Act.

TAB A

The following documentation of state law verifies that the State of Montana has adopted the Uniform Alcoholism and Intoxication Treatment Act. The documentation includes Chapter 302, Session Laws 1974 and Chapters 280 and 403, Session Laws 1975, Montana.

According to Montana Codes, any state legislation which does not specify an effective date becomes effective on July 1 of that calendar year following the Governor's signature. Senate Bill 61 (Chapter 403, Session Laws 1975, Montana) does not specify and effective date and thus shall have the force of law on July 1, 1975.

Also, a copy of Section 94-8-105, R.C.M., 1947 is included for reference which was the section of the criminal code repealed by Chapter 403, Session Laws, 1975.

The 1975 Montana Legislative Session provided legislation which will transfer the responsibilities for state alcohol programming to the

Department of Institutions on July 1, 1975. The act was signed into law by Governor Thomas L. Judge on April 7, 1975. The statute places the State Alcohol Authority for Montana with the Department of Institutions. The State statute (Chapter 280, Session Laws, 1975) providing for this administrative change is included.

Also included is an opinion by the General Counsel of the State Department of Institutions certifying the effective date of the state laws enclosed and certifying that such laws supersede any conflicting or potentially conflicting provisions of state and local laws.

TAB B

The following sections of the Montana codes document the procedures for enforcing state and local laws pertaining to the Uniform Act. The procedures also describe the action to be taken in the event of the non-compliance.

Section 80-2713, Chapter 302, Session Laws, 1974

"(5) The department, after holding a hearing in accordance with the Administrative Procedures Act, may suspend, revoke, limit, or restrict an approval, or refuse to grant an approval, for failure to meet its standards.

(6) A district court may restrain any violation of this section, review any denial, restriction, or revocation of approval, and grant other relief required to enforce its provisions.

(7) Upon petition of the department and after a hearing held upon reasonable notice to the facility, a district court may issue a warrant to the department authorizing it to enter and inspect, at reasonable times, and examine the books and accounts of, any approved public or private treatment facility refusing to consent to inspection or examination by the department or which the department has reasonable cause to believe is operating in violation of this act."

TAB C

Major portions of the Uniform Alcohol Intoxication and Treatment Act were passed by the 1974 Montana Legislative Session and signed into law on March 25, 1974. The 1975 Montana Legislative Session introduced legislation to provide for total decriminalization as outlined in the Uniform Act. The legislation was passed and signed into law by Governor Thomas L. Judge on April 14, 1975. This law, providing for total decriminalization, became effective on July 1, 1975. (Chapter 403, Session Laws 1975, Montana).

The intent of the 1974 Legislature, as stated in the declaration of policy is as follows:

"It is the policy of the State of Montana to recognize alcoholism

as an illness and that alcoholics and intoxicated persons may not be subjected to criminal prosectuion because of their consumption of alcoholic beverages but rather should be afforded a continuum of treatment in order that they may lead normal lives as productive members of society." This Act requires health and treatment standards for alcohol related treatment facilities and standards for acceptance of persons into treatment programs and facilities. The rule is authorized in Sections 80-2713, 80-2714, and 80-2715, Chapter 302, Session Laws 1974. A draft of the rule was developed by the staff of the Alcohol Services Division with the assistance of the Legal Unit of the Department. The draft rule was presented to the Alcohol and Drug Dependency Advisory Council on August 20, 1974 and to interested individuals throughout the state for additional input during preparation. A number of comments and suggestions were incorporated into the rule.

Montana law requires implementation of rules to be processed as outlined in the Montana Administrative Procedures Act. This Act requires public notice in the newpapers and an open public hearing, among other procedures.

The public hearing was held on October 17, 1974 with numerous people from throughout the state submitting formal testimony. Much of the testimony presented was against the adoption of the rule.

John S. Anderson, M.D., Director of the Department of Health and Environmental Sciences was the hearing officer for the hearing on the for for implementation of the porons of the Uniform Alcohol Intoxification and Treatment Act. Dr. Anderson established a task force

whose charge of responsibility was the revising of the rule, with June 30, 1975 as final target date for that recommended revision.

The task force met January 22, 1975, and revised the rule. The revised rule was re-entered into the Administrative Procedures process and a public hearing was held on April 28, 1975. The rule was acceptable to the hearing officer and became effective June 5, 1975. The rule was effective and the law fully implemented on January 1, 1975. (Sec. 80-2721)

TAB D

The following includes an itemized budget for the use of the grant funds. The budget reflects the major emphasis that will be extended by the Alcohol Specialist in the areas of education, training, and technical assistance for FY 77-78. It is intended that the start date for this grant will be September 1, 1977.

			(2 staff)
1.	Personnel - Salaries	$26,232	
	Fringe benefits	3,279	
			$ 29,511
2.	Consultant Services		10,000
3.	Equipment		3,200
4.	Supplies		2,000
5.	Travel		5,000
6.	Treatment		
7.	Publication Costs		5,000
8.	Education Costs - Staff		2,000
	Workshops		22,450

TAB D (continued)

9.	Stipends	
10.	Trainee Tuition/Fees	$ 11,863
11.	Trainee Travel	23,726
12.	Other	
	Evaluation	2,000
	Rent	1,700
	Utilities	300
	Telephone & Postage	1,250
	Total	$ 120,000

The personnel category will allow for two alcohol specialists to be assigned specific areas of responsibility.

The publication cost category will be utilized for reproducing and publishing appropriate training manuals and materials.

Under educational costs a major expenditure is listed for workshops. It is intended that in FY 77 and 78 at least four workshops or training seminars will be conducted in Montana. The workshops will be highly specialized in nature and will require the participation of experts in the fields of law enforcement and treatment.

The categories of trainee tuition/fees and trainee travel will be utilized in assisting persons involved with the alcoholic and alcohol abuser to receive training at approved educational institutions.

TAB E

PROGRAM EVALUATION

To provide for an evaluation system which will encompass the measuring of progress toward achieving the stated objectives of the Implementation Project and the State Plan, and by measuring the progress of the implementation of the Uniform Act by state and local authorities.

This evaluation procedure will be accomplished through measuring project efforts and effects by a quarterly review of progress toward achieving stated objectives. The quarterly review will include an examination of activity reports, records of daily activity, monthly narratives and time lines.

For prevention and training activities, pre-pose test significant procedures will be used when feasible. Evaluation of knowledge and attitude changes will consist of documentation and anecdotal records on the assessment of pre-training functioning versus post-training functioning of target groups.

To develop, pre-test, and implement a management information system which will consist of a simplified data collection form and analysis system by September 1, 1977, which will provide meaningful information to measure program effectiveness to both local programs and Addictive Diseases Bureau, Department of Institutions.

A simplified data collection and analysis format has been developed by Addictive Diseases Bureau, Department of Institutions. This data collection form is currently being pre-tested by four local alcohol programs, each functioning at a different state of development. This method of data collection and analysis, once fully operative, will provide Addictive Diseases Bureau with the necessary information to develop a substantive, well-documented data base and state profile. This monitoring device will allow the bureau to measure referral patterns into alcohol programs from such community services as law enforcement.

To further measure the progress toward achieving full implementation of the Act, the bureau will monitor patterns of arrest within Montana. It is recognized that there are a number of misdemeanor arrest categories that traditionally have been used by law enforcement as alternatives to arrest for public intoxication. The bureau will monitor these arrest categories supplied by the Crime Control Division, Department of Justice, by county, on a semi-annual basis to determine if law enforcement agencies are, in fact, complying with the Uniform Act.

As it becomes feasible, the bureau will establish agreements for evaluation and monitoring with other human and health services both on a state and local level. This activity will require close working arrangements being established with such agencies as the Welfare Department, local health departments, and Mental Health Centers.

TAB F

ASSURANCES

1. This state agency, as the applicant agency, assures that the federal funds under this grant will not supplant State, local and other non-Federal funds otherwise available for providing services and performing activities under the grant. Assurances also are given that the grant funds will be used wherever practical to increase the level of funds otherwise available for such services and activities.

TAB F (continued)

2. The OMB A-95 review and comment will be supplied by the State Clearinghouse as soon as possible.

3. Objectives and activities as detailed in this grant proposal are considered long-term priorities by this State agency. The commitment for this long-term programmatic activity is found in detail in the 1975 Montana State Plan for Alcoholism and Alcohol Abuse.

Adoption of the Uniform Act included sections to provide State monetary support for implementation. Revenue is provided by an increase of one percent in the liquor revenue tax and the monies accrued are deposited in the State general fund. $500,000 was appropriated from the general fund for implementation of the Act in FY 1975.

Listed below is the total source of funds for Alcohol Services Section of the Addictive Diseases Bureau for FY 1976:

FY 76 State General Fund	$593,227
FY 75 P.L. 91-616 Federal Grant (NIAAA)	225,000
	$818,227

WORK PLAN - UNIFORM ACT

GOAL: To develop on a local, regional and statewide basis, a continuum of care for the medium and high alcohol addiction risk population; and which will provide for the implementation of the Uniform Act.

OBJECTIVES:

1. To insure that a referral mechanism is operative in each of the 56 counties in Montana which will provide the intoxicated person with detoxification and emergency services.

The Addictive Diseases Bureau will assist in the development and implementation of written affiliations between local alcoholism programs and health care facilities to insure that a proper referral mechanism is maintained between these community services.

Staff from the Addictive Diseases Bureau will promote and conduct public forums, workshops and seminars for law enforcement personnel, and other service agencies and individuals to insure that the intoxicated person receives proper detoxification and other emergency care as deemed necessary. The conducting of seminars and workshops will include presentations to: the Law Enforcement Academy at Montana State University; in-service staff training for law enforcement agencies; and Probation and Parole; staff training programs for human and social services both on a state and local level; and the in-service training programs of the major hospitals in the State.

2. To approve alcohol treatment facilities which meet the requirements of rules for implementing Sections 80-2713, 80-2714 and 80-2715, R.C.M. 1947.

The Addictive Diseases Bureau will solicit requests from alcohol programs for approval as acceptable treatment facilities. The requests

for approval will be required to be in writing and must present documentation of the facilities' compliance with the rule. A site visit by Bureau staff will be arranged for each applicant seeking approval. When the applicants are approved as acceptable alcoholism treatment facilities, they will become eligible for funding.

Addictive Diseases Bureau will compile annually a list of approved treatment facilities for distribution statewide.

3. To assist alcohol programs, which do not meet the minimum standards set forth in the rule, to upgrade and/or develop appropriate service components so that they will comply with the rule by September 1, 1977.

The Bureau staff will provide technical assistance and consultation to alcohol programs by assessing the needs of programs and assisting in the development of services which are presently lacking or non-effective.

4. To encourage and foster the development of alcohol services in those areas where no resources are presently available to assure that, as a minimum, information and referral capabilities will be available to the 56 counties in Montana by August 1, 1977.

The Addictive Diseases Bureau will be principally concerned in generating support and interest among community and target populations in these areas to include law enforcement, government officials, and medical personnel. The Bureau staff will foster the development of task forces or committees within these areas.

These committees can provide the basis for the development of alcohol programs which will meet the needs of a service area.

It is anticipated that Bureau personnel will concentrate much of their efforts in areas where no services are currently available in order to assist in the development of adequate services for the alcoholic and alcohol abuser.

5. To insure a continuum of care by referral of individuals discharged from alcoholism treatment facilities to approved local alcoholism programs by September 1, 1977.

Procedures will be established whereby treatment facilities will refer discharged clients to approved alcohol programs to insure that proper follow-up services are maintained.

The alcohol specialists will coordinate, and provide technical assistance to local alcohol programs to insure the delivery of followup services. Addictive Diseases Bureau will negotiate and develop methods to insure services for those individuals returning to Montana from out-of-state treatment facilities.

Addictive Diseases Bureau will monitor and measure the effectiveness of follow-up services through a monthly report summarizing admissions, dismissals and referrals provided by approved local alcohol programs and alcohol treatment facilities.

6. To provide technical assistance to alcohol programs so that an

effective followup system will be developed and implemented statewide by September 1, 1977.

Follow-up will be designed to provide care to patients who have progressed sufficiently through emergency inpatient, intermediate and/or outpatient services to a point in their recovery where they would benefit from a level of continued contact which will support and increase the gains made to date in the treatment process.

Addictive Diseases Bureau will actively assist community alcohol program in establishing effective follow-up systems by providing direct technical assistance, conducting workshops and seminars on the subject, and by providing for other relevant training.

IMPLEMENTATION PROJECT

General

In the past, the amount of service that could be provided to communities and local alcohol programs by the Addictive Diseases Bureau has been limited by constraints of limited staff and distance. In addition, H.B. 909 (Chapter 302, Session Laws, 1974) signed by Governor Thomas L. Judge, March 25, 1974, placed new responsibilities on the State Department of Institutions. This law directs the Department to "develop, encourage and foster statewide, regional and local plans and programs for the prevention of alcoholism and treatment of alcoholics and intoxicated persons..., and provide technical assistance and consultation services for these purposes." The Act further instructs the

Department to "establish a comprehensive and coordinated program for the treatment of alcoholics and intoxicated persons" and "provide for adequate and appropriate treatment for alcoholics and intoxicated persons."

Furthermore, Addictive Diseases Bureau has maintained a long-term commitment to provide training and education for those persons involved with the alcoholic and alcohol abuser. With the added responsibilities imposed by recent legislation this training and educational effort must be expanded greatly.

In order to fulfill these obligations, the staff of the State Authority must be expanded and major new efforts undertaken in the training of those involved with the alcoholic and alcohol abuser. To best utilize an expanded staff, it is proposed that program specialists with special capabilities in the fields of law enforcement and treatment be employed. The specialists would facilitate the maintenance of communication between local programs, communities and the state office. Most importantly, the specialists would assist the state in fulfilling the obligations and responsibilities as dictated by law.

PROJECT OBJECTIVES

1. To develop and implement a system of referral and aftercare which will insure a continuum of care for the alcoholic either re-entering society or seeking assistance from a proper treatment facility.

2. To establish a system of care which is accessible statewide. The system would include the services of inpatient care, emergency services, outpatient services, intermediate care and prevention.

3. To assist and be involved in developing primary prevention activities on a community and statewide basis through a positive alcohol education program.

4. To provide technical assistance in the development of appropriate methods and systems necessary to evaluate all components of the alcohol services care system.

5. To determine the needs for training and to assist in the development and implementation of training programs designed to meet the needs of professional and paraprofessional staff on a local, regional and statewide basis.

METHODS

The staff of the Implementation Project will consist of two alcohol specialists to be assigned distinct areas of responsibilities such as law enforcement, treatment, and minority groups. Each specialist will be responsible for assigned activities in their respective areas.

The specialists will provide information, training and technical assistance to key agencies and persons at the state and local levels necessary for implementation of the Uniform Act. The following breakdown of activities shows areas of responsibilities as assigned to specialists.

Law Enforcement: Will work primarily in the area of providing education, training and technical assistance necessary for the implementation of the Uniform Act to key personnel in the Department of Justice, Board of Pardons, Penal System, Law Enforcement Academy, Highway Patrol, Court System, Highway Traffic Safety, and local law enforcement officials.

Treatment: Will provide technical assistance, education, and training to hospital and medical staff, professional medical organizations, health and human service agencies, and alcohol program staff.

The treatment specialist will assist local programs in meeting minimum standards set forth in the rule, to upgrade and/or develop appropriate service components so that they may comply with the rule.

Both the Work Plan and the Implementation Project have been incorporated into the 1975 Montana State Plan for Alcoholism and Alcohol Abuse and are compatible with that document.

MONTANA STATE PLAN FY 76

INTRODUCTION AND NEEDS ASSESSMENT

The following information portrays patterns and trends of alcohol use, and the conditions of alcoholism and alcohol abuse within Montana. Also included is a needs assessment which demonstrates the need for assistance.

Alcoholism and alcohol abuse are conditions that are found among all age and ethnic groups within Montana. However, a sense of urgency is being felt on a national, state and local level that these conditions are especially prevalent among special identifiable groups.

The following information provides indicators and trends of alcoholism and alcohol abuse among special high risk groups within Montana. State and local efforts can be more effectively directed, resources can be better utilized and a much greater impact can be realized in reducing the incidence of alcoholism and alcohol abuse in Montana, with these groups identified.

Apparent Consumption

Montana ranks among the states in apparent consumption age 15 and over as 24th in distilled spirits, 37th in wine and 5th in malt beverages. When compared to the U.S.A. average of apparent consumption in U.S. gallons per person in the drinking-age population (age 15 and over), as shown in Table I, Montana ranks close to the national average in distilled spirits, considerably lower in wine and much higher in the consumption of malt beverages.

TABLE I

APPARENT CONSUMPTION BY MONTANA AND U.S.A.
OF MAJOR BEVERAGE CLASS IN U.S. GALLONS PER PERSONS
15 YEARS OF AGE AND OLDER, 1972[1]

	Distilled Spirits	Wine	Malt Beverages
Montana	2.52	1.14	34.94
U.S.A.	2.60	2.16	26.62

It also is significant to compare the apparent consumption of absolute alcohol in U.S. gallons per person age 15 and over for the U.S.A., the Mountain Region and Montana (1972). The apparent consumption for the U.S.A. is 2.63, the Mountain Region 2.92, and Montana 2.81.[2]

The percent rate of increase in the apparent per capita consumption of alcoholic beverages in Montana from 1961 through 1972 has been approximately 11 percent. Figure I demonstrates this steady annual rise in apparent consumption of alcohol beverages over a twelve year period. In this time frame the increase in apparent consumption of malt beverages has been 8.2 percent, 15.2 percent for wine and 9.6 percent for distilled spirits.[3] Table II demonstrates the annual increase in apparent consumption of alcohol beverages.

One indicator which demonstrates the increase in problem drinking rates and which compares with the apparent increase in consumption is the alcohol related misdemeanor arrests for Montana. Figure II demonstrates the steady annual increase in the number of arrests for Public Intoxicant and DWI. The increased rates for DWI was 30.2 percent for 1971-72 and 12.8 percent for 1972-73. The 12.8 percent increase between 1972 and 1973 can be considered to be most representative of anticipated future rate increases.

Risk Groups

In attempting to define risk groups within the total population, two basic sources of information were used to develop indicators: 1) arrest data supplied by the Crime Control Division, Montana State Department of Justice; and 2) the R.A.P. Scale test.

The following is a description of the R.A.P. Scale test and a series of matrixes which were extrapolated from the test and applied to the white population of Montana age 15 and over. The methodology seeks to identify persons with potential alcohol problems. It is assumed that persons from a group which can thus be categorized can be considered potential clients for alcoholism services.

The estimates are derived from a survey that has already been done, estimates of the degree of alcohol abuse risk in various age groups are taken, and finally aggregate figures that reflect age group dispersion of the state's population are arrived at.

The estimate of risk within the state's population was based upon an assessment of needs study conducted by the Rimrock Guidance Foundation, Yellowstone County, in 1972-73. The study utilized the R.A.P. Scale test which is designed to measure risk of addiction. A total of 3,156 R.A.P tests were administered, involving 5.2 percent of the "risk" white population (15 years of age and older) of Yellowstone County. It was directed toward both rural and urban segments of that county population.

Certain differences are apparent between the composition of the state's white population and that of Yellowstone County's white population. The most apparent differences are in density, urban vs. rural and types of employment. However, for purposes of establishing estimates of addiction risk, comparisons are made between various age groups from the state and Yellowstone County white population.

---

1 Alcohol and Health, New Knowledge (1974), p. 3.

2 The higher consumption rate of the Mountain Region is due to one state - Nevada - which has the second highest consumption rate in the country. Ibid., p. 3-4.

3 Percents are computed from indexes found in Table II.

Two aspects of the R.A.P. test must be qualified: 1) the test apparently does not utilize any mechanism to handle non-responses to the questionnaire; and 2) the questionnaire is soliciting attitudinal responses. It is understood that either item can, to a varying degree, affect the final results of such a study.

It was concluded by the study group that the age group 15-29 demonstrated a large numerical percentage of higher risk with the 15-19 age subgroup representing the largest percentage of high risk of all age grouping. The study concluded that without corrective action in the younger age grouping, Yellowstone County could be faced with an addictive rate of 8-9 percent of the general population within ten years.

The conclusions from the Yellowstone County study that an 8-9 percent addiction rate is quite possible, is close to the estimate of the Alcohol Services Division that the percentage of alcoholics among the white population is 8.5 percent.

The following matrixes are based upon the risk percentage from the Yellowstone County study and are applied to select statewide white population groups. The aggregate of these groups is to be considered the white risk population.

ESTIMATE OF ALCOHOL ADDICTION RISK
STATE OF MONTANA
1973

Matrix 1 White Risk Population			Matrix 2 Percent High Risk			Matrix 3 Estimate Number High Risk	
Age	Number		Age	Percent		Age	Number
15-19	66620		15-19	9.3		15-19	6196
20-24	48951		20-24	6.9		20-24	3378
25-29	40266		25-29	7.6		25-29	3060
30-34	35900	X	30-34	4.3	=	30-34	1544
35-39	34736		35-39	5.9		35-39	2049
40-44	37365		40-44	6.1		40-44	2279
45+	200296		45+	4.5		45+	9013

TOTAL 27519

White Risk Population

Age	Number
15-19	66620
20-24	48951
25-29	40266
30-34	35900
35-39	34736
40-44	37365
45+	200296

X

Matrix 4
Percent Medium Risk

Age	Percent
15-19	23.5
20-24	15.6
25-29	13.7
30-34	11.7
35-39	11.4
40-44	10.8
45+	10.2

=

Matrix 5
Estimate Number
Medium Risk

Age	Number
15-19	15656
20-24	7636
25-29	5516
30-34	4200
35-39	3960
40-44	4035
45+	20430

TOTAL 61433

White Risk Population

Age	Number
15-19	66620
20-24	48951
25-29	40266
30-34	35900
35-39	34736
40-44	37365
45+	200296

X

Matrix 6
Percent Higher Risk
(High/Medium)

Age	Percent
15-19	32.8
20-24	22.5
25-29	21.3
30-34	16.0
35-39	17.3
40-44	16.9
45+	14.7

=

Matrix 7
Estimate Number
Higher Risk

Age	Number
15-19	21851
20-24	11014
25-29	8577
30-34	5744
35-39	6009
40-44	6315
45+	29444

TOTAL 88954

Within limits, the use of alcohol related misdemeanor arrests data can be used to demonstrate risk groups with respect to age, race, and sex.4 Table III and Figure III demonstrates the large number of persons age 12 through 29 who are arrested for DWI and Public Intoxicant. Further, the age subgroup 20-29 which represents approximately 19.2 percent of the total risk population were responsible for 57.3 percent of the arrests in the two categories.

Table IV presents the number of arrests related to race and sex. While the Indian population represents approximately 3.9 percent of the total population,[5] this group was responsible for 67.4 percent of Public Intoxicant arrests, and 26.6 percent of DWI arrests in 1973.

Table IV also demonstrates that alcohol related misdemeanor arrests predominately involve males. In 1973, only 13.4 percent of total arrests for Public Intoxicant and DWI involved females.

Conclusions

Age

In Montana, the apparent consumption of alcohol beverages is increasing at a predictable annual rate. This annual increase cannot be explained by the increases in those groups which annually "enter" the drinking pipulation. Further, the consumption figures used in this report do not explain the consumption rates of age groups under 21 years of age. However, national surveys have concluded that a large portion of teenagers consume alcohol beverages. Among the young population, beer is the beverage of choice. These surveys also conclude that the quantity of alcohol consumed increases with school grade.[6]

The matrixes developed from the R.A.P. Scale test study show that the risk of addiction to alcohol or the development of problem drinking is extremely high for the 15 through 19 age group. It is concluded from the matrixes that while this age group represents approximately 14.4 percent of the total white "risk" population it scores extremely high in percent of high risk (22.5 percent), medium risk (25.5 percent) and combined high/ medium risk (24.6 percent). The next highest scoring group developed from the matrixes is the 20 through 29 age group. This group representing 19.2 percent of the white risk population totalled 23.4 percent high risk, 21.4 percent medium risk and 22.0 percent combined high/medium risk

The matrixes substantially agree with the conclusions found in Alcohol and Health. New Knowledge that the age group 18-20 has the largest portion of individuals that experience "some problem in connection with drinking (27%), followed by those aged 21 to 24 (18%)..."[7] Earlier national studies, which had not included the age group 18-20, reported the 21-25 age group having the highest ratio of alcohol related problems.

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4 Methods of collecting arrest data and possible prejudices of arresting officers can to an extent influence the arrest figures used in this report.

5 Division of Comprehensive Health Planning, SDH&ES (1973) County Profile, p.33

6 Alcohol and Health, New Knowledge (1974), p.8

7 Ibid, p. 25

National studies indicate that males in their early 20's most frequently experience drinking problems.[8] This observation generally is confirmed in Montana by using the indicator of alcohol related misdemeanor arrests in the age group 20-29. This group presents an extremely high ratio of arrests to population number (see Tables III and IV).

From studies conducted both on a national level and within Montana, and from available indicators it is apparent that the younger population (15-39) represents a special high risk group.

Indian

It has been well established that ethnic background has a large bearing on drinking patterns,[9] and subsequently on the incidence of alcoholism and alcohol abuse. However, it is very difficult to accurately determine the incidence of these conditions among the Indian population of Montana. This difficulty is due to the fact that the estimates of incidence varies from 10 percent to 50 percent of that population. It is assumed, however, that indicators are available which can be of value in determining the extent of the problem among this specific population.

For this report, two indicators are used to assist in determining the extent of alcoholism and alcohol abuse among the Indian population: 1) alcohol related misdemeanor arrests by offense and race; and 2) cause of death data.

Table IV demonstrates the disproportionately high rate of Indian arrests for Public Intoxicant and DWI as compared to the white population.

While these figures may, to an extent, be inflated by external factors, they still appear to be significant.

The Bureau of Records and Statistics, State Department of Health and Environmental Sciences, maintains a continual surveillance of mortality data and provides an analysis of cause-of-death data. In a recent report (October 11, 1974) this Bureau reported a significant increase in cirrhosis of the liver in non-white females. The 1973 death rate for cirrhosis of the liver in non-white females was 99.0 as compared to the 1970-72 death rate of 46.2, which represents a statistically significant increase in the incidence of this disease. Numerous studies (Terris, 1967; Tokuhata, 1971) have demonstrated that a direct correlation exists between the levels of alcohol consumption and death rates from cirrhosis of the liver. The death rate for non-white females increased considerably in 1973 whereas the incidence of this condition among whites is down. The above information indicates that the apparent consumption of alcohol beverages for non-white females has increased significantly as well as the rates of alcoholism.[10]

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8 Ibid, p.25

9 Ibid, p. 7

10 A test of significance utilizing the Chi-Square technique was used in this report. This category reported a Chi-square of 5.6427. Rates are based on death rates per 100,000 population.

Cirrhosis of the liver is a chronic degenerative disease which can be caused by liver infections and blood disorders, but is most usually associated with nutritional problems frequently contributed to chronic alcoholism.

MONTANA STATE PLAN FY 76

TABLE II

INDEXES OF APPARENT PER CAPITA CONSUMPTION OF
ALCOHOLIC BEVERAGES (1961-72)
MONTANA
CONSUMING POPULATION (21 years of age and older)

Calendar Year	Beer Consuming Population		Wine Consuming Population		Distilled Spirit Consuming Population	
	Gallons	Index 1961=100	Gallons	Index 1961=100	Gallons	Index 1961=100
1961	32.9	100.0	.73	100.0	2.02	100.0
1962	34.0	104.3	.69	97.2	2.13	102.6
1963	34.9	105.7	.69	97.2	2.15	103.1
1964	35.0	108.5	.71	98.6	2.20	104.2
1965	36.3	110.5	.74	100.7	2.31	106.3
1966	36.9	111.4	.77	102.7	2.43	108.9
1967	38.6	113.8	.83	106.6	2.51	110.6
1968	37.3	111.9	.90	110.9	2.64	113.4
1969	38.7	113.9	.90	110.9	2.75	115.7
1970	42.4	119.1	1.03	118.3	2.83	117.3
1971	43.5	120.6	1.15	124.8	2.93	119.3
1972	42.0	118.4	1.37	135.6	3.02	121.1

The above table has been derived from per capita consumption based on the total alcohol beverage consuming population - instead of per capita consumption based on total population. This procedure was followed because the use of raw population data does not take into account shifts in the relative growth of the young population. In 1950, 37 percent of the total population in Montana was under 21 years of age; in 1960, 42.4 percent was under 21 years of age; and by 1970, that ratio had dropped to 41.7 percent.

The consumption indexes shown in this table represents the tax-paid quantities of alcohol beverages that enter consumer outlets. It does not show those that leave consumer outlets and thus such items as inventory overloads may distort apparent consumption in any given year.

MONTANA ALCOHOL RELATED MISDEMEANOR
ARRESTS BY OFFENSE & AGE[1]
1973[2]

AGE	PUBLIC INTOXICANT	PERCENT OF AGE CATEGORY	DWI	PERCENT OF AGE CATEGORY	TOTAL OFFENSES	PERCENT OF AGE CATEGORY
1-11	6	.1	1	0.0	7	0.0
12-19	1455	14.4	307	8.9	1762	13.0
20-29	2462	24.4	1137	32.9	3599	26.5
30-39	1974	19.5	703	20.3	2677	19.7
40-49	1948	19.3	647	18.7	2595	19.1
50-59	1387	13.7	440	12.7	1827	13.5
60 & over	650	6.4	169	4.9	819	6.0
Unknown	228	2.2	54	1.6	282	2.1
TOTAL	10110	100.0	3458	100.0	13568	100.0

TABLE IV

MONTANA ALCOHOL RELATED MISDEMEANOR
ARRESTS BY OFFENSE, RACE & SEX
1973

OFFENSE	RACE			SEX	
	WHITE	INDIAN	OTHER	MALE	FEMALE
Public Intoxicant	3195	6814	101	8611	1499
DWI	2506	920	32	3137	321
TOTAL	5701	7734	133	11748	1820

[1]Crime Control Division, Department of Justice, State of Montana

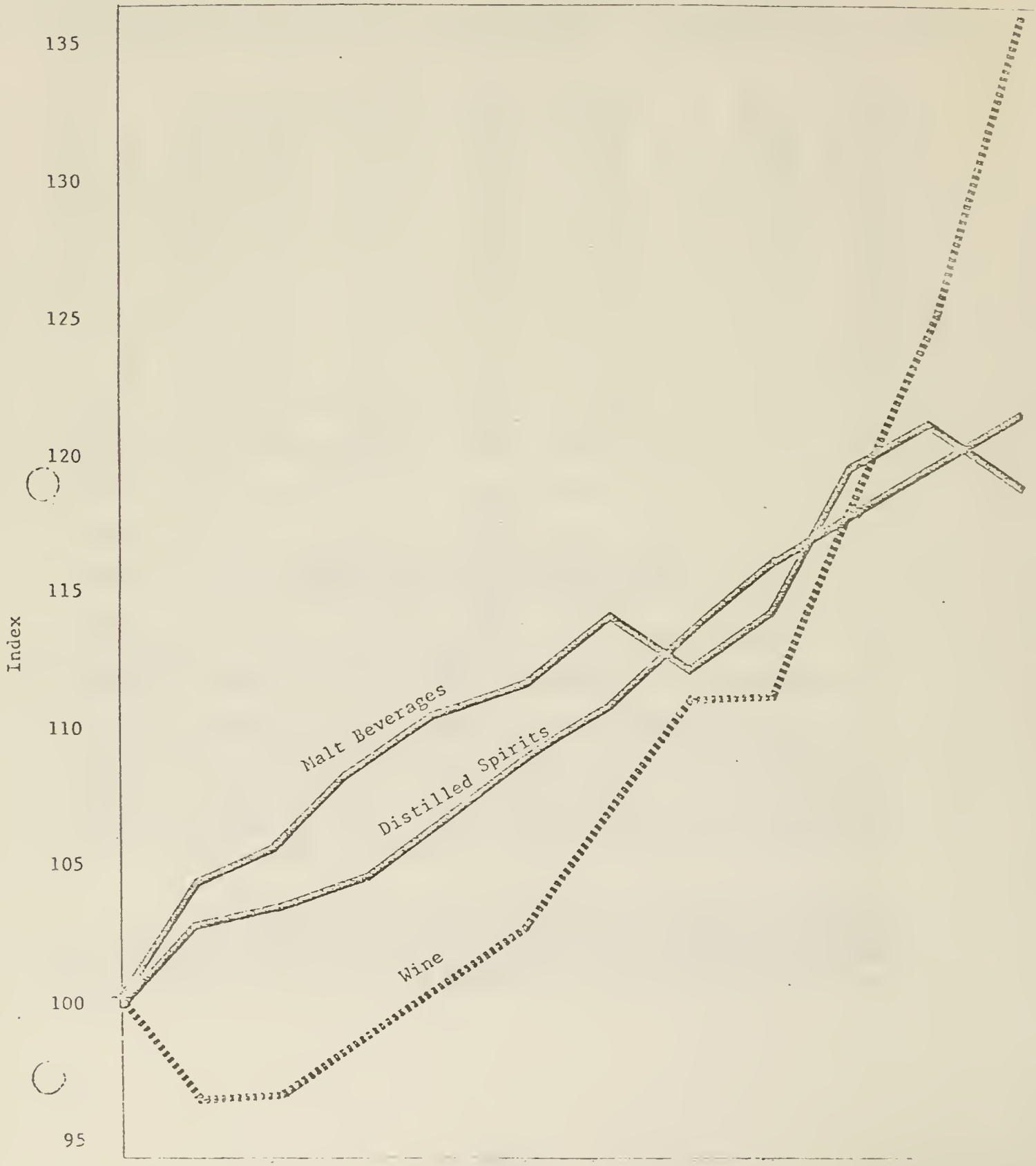
[2]In addition, many other arrests listed in records as disorderly conduct, disturbing the peace, vagrancy and others are commonly known to refer to public intoxication.

FIGURE I MONTANA STATE PLAN FY 76

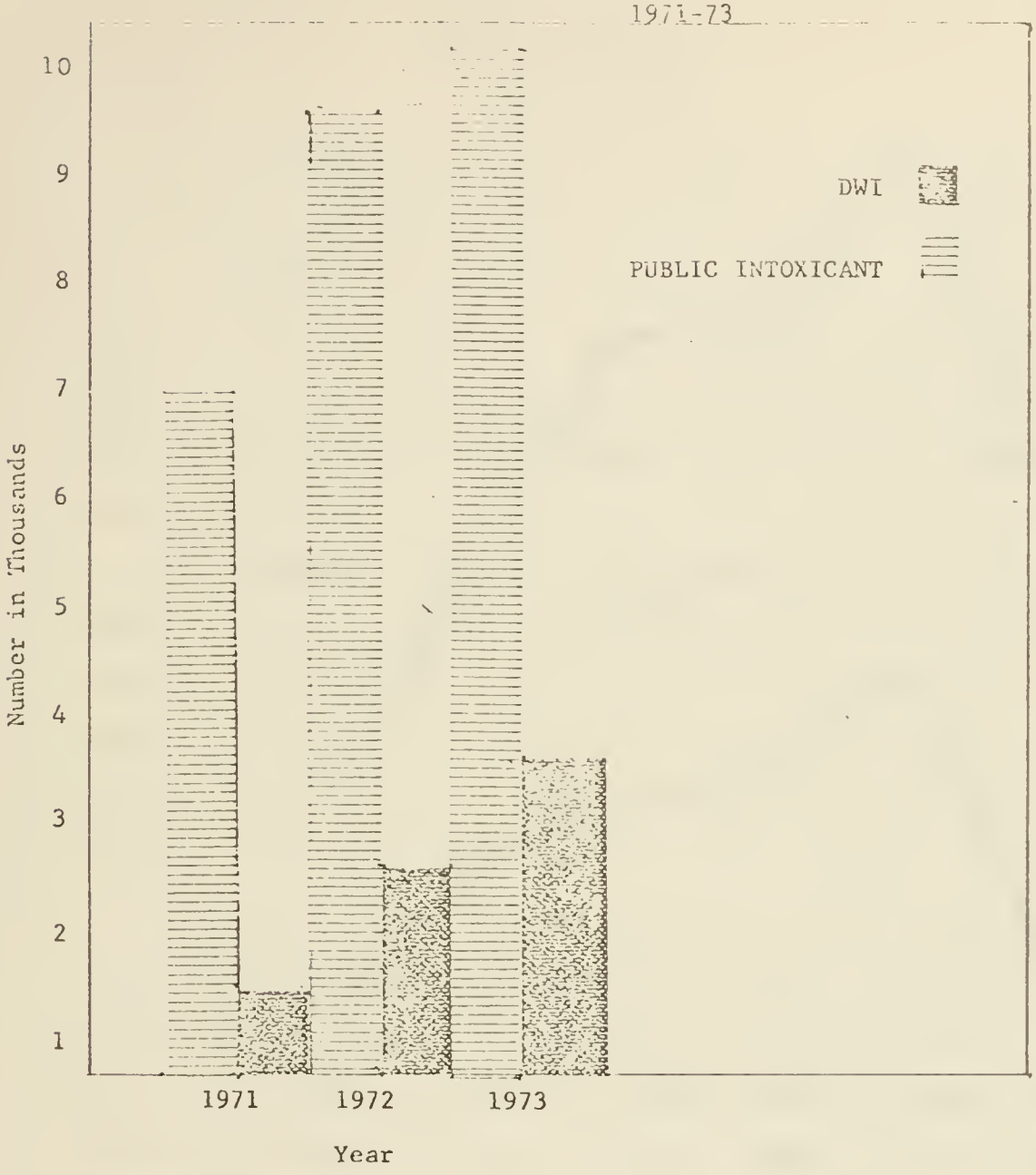
INDEXES OF APPARENT PER CAPITA CONSUMPTION OF ALCOHOLIC BEVERAGES

1961 through 1972

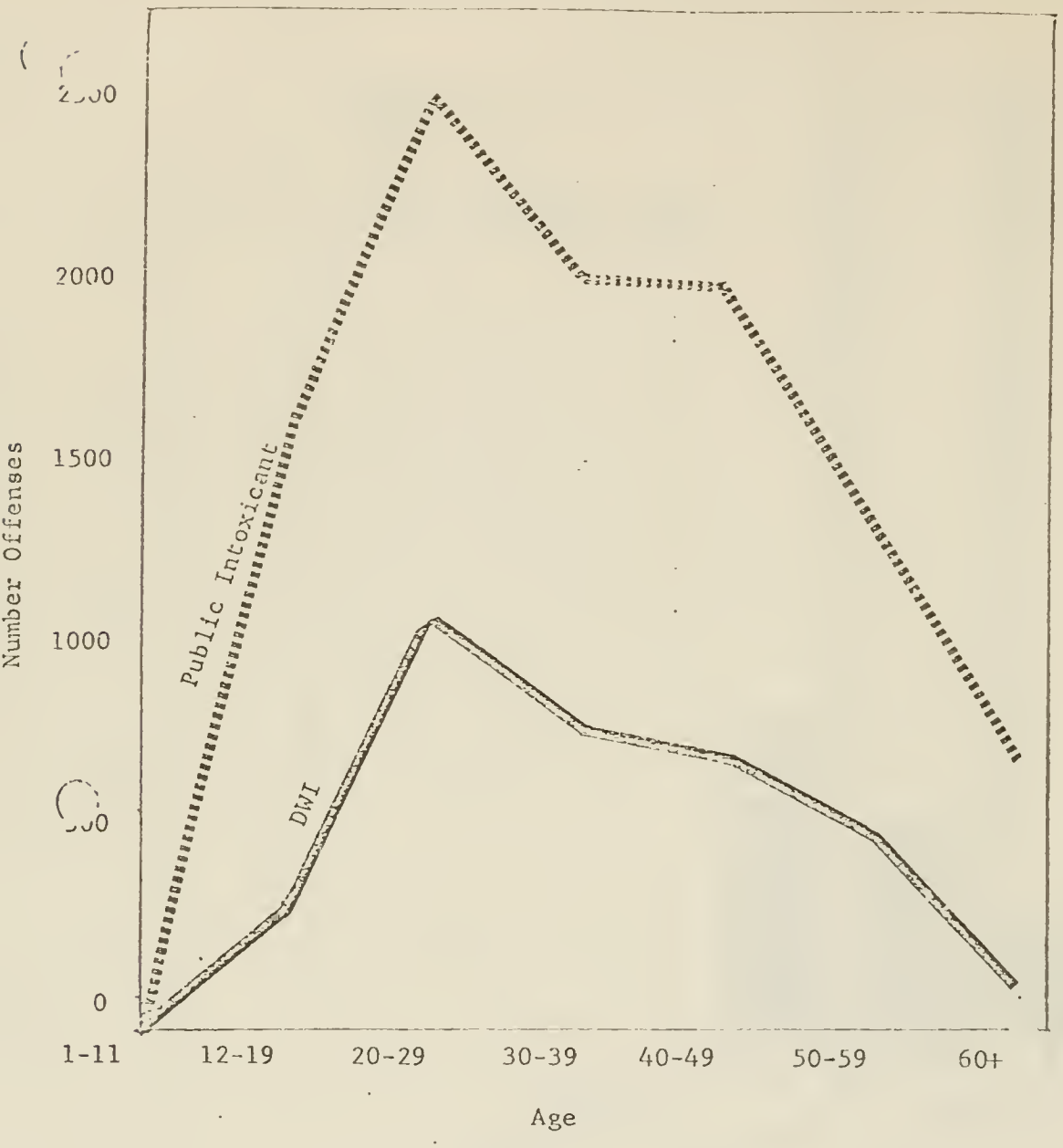
CONSUMING POPULATION (21 years of age and older)



MONTANA ALCOHOL RELATED MISDEMEANOR ARRESTS BY OFFENSE AND YEAR
1971-73



MONTANA ALCOHOL RELATED MISDEMEANOR ARRESTS BY OFFENSE & AGE
1973



MONTANA STATE PLAN FY 76

NEEDS ASSESSMENT

Available indicators identify the age group 15 through 29 as a special high risk group in Montana. For this age group, the indicators can be considered, to a great extent, to be manifestations of alcohol abuse and irresponsible attitudes toward drinking. There is a direct link between irresponsible attitudes toward drinking and the problem of alcoholism, therefore, a special emphasis must be directed toward this issue and age group.

The programmatic activity which would have the greatest long-term impact is prevention. Prevention activities must include not only the assisting of young people to adopt themselves realistically to a predominantly "drinking" society, but also to clarify and emphasize the distinctions between acceptable and unacceptable drinking, and to reduce the emotionalism associated with alcoholic beverages.

Another identifiable high risk group is the Indian population of Montana. While a great amount of funding and effort is being channeled into Indian alcohol programs, the impact of this expanded effort is difficult to assess. In the future, attention must be focused on the direction and management of these programs. Special consideration must be given to the unique and special needs of this high risk group.

The Alcohol Services Division, in the past, has initiated regional needs assessments and planning. This process involved the utilization of the Comprenensive Health Planning "B: agencies and Montana Indian Commission on Alcohol and Drug Abuse. The individual regional assessments have been compared and grouped in order to identify patterns and similarities that can be applied statewide.

The areawide alcoholism plans concluded that major new efforts are required in all aspects of prevention: to include formal on-going educational efforts in the school system, community education, public awareness campaigns, and a coordinate effort by those persons and agencies involved in prevention activities.

The regional needs assessments regarded the regionalization of alcohol program efforts as a major necessity. Equally important, is the need for the coordination of local resources. Action for Eastern Montana's Alcoholism Plan suggested that the coordination could be best achieved through the establishment of a Regional Alcoholism Coordinating Office. From a state programmatic viewpoint, such an approach to regionalization would be beneficial in that it wouuld allow state agencies to better assist local alcohol programs in providing services to the general public.

A common theme from the regional plans was that the utilization of existing public services and community involvement/support are mandatory priorities. The plans regarded the expansion and upgrading of treatment facilities and program as a serious priority. The need for improved follow-up and outreach procedures also was expressed, as well as needs in the areas of in-service training and a useable data system. Special concern was also expressed for the needs of the urban Indian.

(2) A person convicted of the offense of riot shall be fined not to exceed five hundred dollars ($500) or be imprisoned in the county jail for a term not to exceed six (6) months, or both.

History: En. 94-8-103 by Sec. 1, Ch. 513, L. 1973.

Source: New.

Commission Comment

The common-law misdemeanor, "unlawful assembly," was a gathering of three or more persons with the common purpose of committing an unlawful act. When an act was done toward carrying out this purpose, the offense was "rout." The actual beginning of the perpetration of the unlawful act became "riot." All states penalize some form of unlawful assembly or riot. The section follows the common law with the exception of the number of people involved and the inclusion of the language "purposely and knowingly," which is the standard mens rea requirement in the code.

94-8-104. Incitement to riot. (1) A person commits the offense of incitement to riot if he purposely and knowingly commits an act or engages in conduct that urges other persons to riot. Such act or conduct shall not include the mere oral or written advocacy of ideas, or expression of belief, which advocacy or expressions does not urge the commission of an act of immediate violence.

(2) A person convicted of the offense of incitement to riot shall be fined not to exceed five hundred dollars ($500) or be imprisoned in the county jail for a term not to exceed six (6) months, or both.

History: En. 94-8-104 by Sec. 1, Ch. 513, L. 1973.

Source: New.

Commission Comment

This section introduces a new concept to the Montana Criminal Code. The intent of the section is to specifically define an offense which might otherwise be covered in another part of the code.

It is conceivable that an act constituting incitement to riot would be covered under the inchoate offense of solicitation. However, with the increase in the general social upheaval in many jurisdictions, a single statute specifically prohibiting incitement to riot might provide more effective law enforcement. Preventing a riot before substantial injury to property and persons has occurred is the only practical method of dealing with such social unrest, for after the substantive offenses are committed, and a riot is in progress, normal law enforcement procedures are generally unworkable and the tactics used by enforcement officials to restore order often extend beyond that which may be considered a reasonable use of force under the circumstances.

94-8-105. Public intoxication. (1) A person commits the offense of public intoxication if he appears in a public place in a state of visible intoxication as a result of the use of alcohol or any dangerous drug and is

(a) creating a risk to himself or others, or

(b) conducting himself in an offensive manner.

(2) A person convicted of the offense of public intoxication shall be fined not to exceed fifty dollars ($50) or be imprisoned in the county jail for a term not to exceed ten (10) days, or both.

History: En. 94-8-105 by Sec. 1, Ch. 513, L. 1973.

Source: Substantially the same as Model Penal Code, section 250.5.

Commission Comment

The primary intent of the section is to authorize taking the offender into custody for his own protection and to prevent further public disorder. Incarceration is no cure for alcoholism but it may be a means of directing the offender toward helping services.

Department of Institutions

GOVERNOR
THOMAS L. JUDGE

DIRECTOR
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Helena, 59601

April 14, 1976

Larry Carlson, Administrator
Adaptive Services Division
Department of Institutions
1539 11th Avenue
Helena, Montana 59601

Dear Dr. Carlson:

I have examined the current law concerning Chapter 302 of the 1974 Montana Legislature providing for the acceptance of persons into alcoholism and intoxication treatment programs and involuntary commitment of alcoholic persons, and Chapter 403 of the 1975 Session, which repealed Section 94-8-105, R.C.M. 1947 which classifies public intoxication as a criminal offense.

The aim of this letter is to certify that the effective date of Chapter 403 of the 1975 Legislative Session was July 1, 1975. In this regard Section 43-507, R.C.M. 1947 provides that every statute takes effect on July 1 of the year that it is passed and approved unless a different time is prescribed in the bill. Therefore, the law repealing the criminalization for alcoholism was effective July 1, 1975. This statute will supercede any conflicting county or city ordinance in Montana.

It is my opinion that the legislation enacted by the State of Montana in 1974 and 1975 meets Sections 1, 10, 14, and 19 of the Uniform Alcoholism and Intoxication Treatment Act.

Very truly yours,

Nick A. Rotering

Nick A. Rotering
Special Assistant Attorney General

NAR/clm

302

HOUSE BILL NO. 909

INTRODUCED BY FASBENDER, CAMPBELL, DRISCOLL, SWANBERG, MARKS MCKITTRICK, GREELY

AN ACT ADOPTING CERTAIN PROVISIONS OF THE UNIFORM ALCOHOLISM AND INTOXICATION ACT, INCREASING THE TAX ON ALCOHOLIC BEVERAGES TO CREATE A FUND FOR THE PROGRAMS AUTHORIZED BY THIS ACT, AMENDING SECTIONS 4-201, 4-240, 4-324, 11-927, AND 94-8-105, R.C.M. 1947, AND REPEALING SECTIONS 4-164 AND 69-6202, R.C.M. 1947.

This bill was received by the Governor this 16 day of March 1974

Thomas L. Judge
Governor

By

Approved 3-23-74

Thomas L. Judge
Governor

STATE OF MONTANA
DEPARTMENT OF SECRETARY OF STATE
FILED
March 25 1974
AT 3:00 P M
Frank Murray
SECRETARY OF STATE
BY Glenn Woodgerd
DEPUTY

HOUSE BILL NO. 909

INTRODUCED BY FASBENDER, CAMPBELL, DRISCOLL, SWANBERG, MARSH, MCKITTRICK, GREELY

IN THE HOUSE

SECOND REGULAR SESSION

January 17, 1974	Considered read and referred to Committee on Judiciary.
February 15, 1974	Committee recommends bill do pass as amended. Report adopted and referred to Bills Committee for printing.
February 19, 1974	Reported correctly printed. Report adopted. Referred to second reading.
February 20, 1974	Recommended favorably by Committee of the Whole as amended. Report adopted and referred to Bills Committee for engrossing.
February 21, 1974	Reported correctly engrossed. Report adopted and referred to calendar for third reading.
	On motion rules suspended and bill placed on third reading this day.
	Read three several times and passed. Title and history agreed to. Transmitted to the Senate for its concurrence.

IN THE SENATE

February 22, 1974	Considered read and referred to Committee on Taxation.
February 28, 1974	On motion taken from Committee on Taxation. Referred to Committee on Public Health, Welfare and Safety.

March 8, 1974	Committee recommend that bill be concurred in. Report adopted. Bill referred to second reading.
	On motion placed on second reading for consideration this day.
	Committee of the Whole recommend that further action be indefinitely postponed. Report adopted.
	On motion segregated from report of Committee of the Whole.
	Passed consideration.
March 9, 1974	Committee of the Whole recommend bill be concurred in as amended. Report adopted. Referred to calendar for third reading.
	On motion rules suspended. Bill placed on calendar for third reading this day.
	Read third time and concurred in as amended. Title and history agreed to. Returned to House for concurrence in Senate amendments.

IN THE HOUSE

March 11, 1974	Referred to second reading for concurrence in Senate amendments.
March 12, 1974	Senate amendments concurred in by Committee of the Whole. Placed on calendar for third reading.
March 13, 1974	Senate amendments concurred in on third reading. Referred to Bills Committee for enrolling.
	Reported correctly enrolled.

AN ACT ADOPTING CERTAIN PROVISIONS OF THE UNIFORM ALCOHOLISM AND INTOXICATION ACT, INCREASING THE TAX ON ALCOHOLIC BEVERAGES TO CREATE A FUND FOR THE PROGRAMS AUTHORIZED BY THIS ACT, AMENDING SECTIONS 4-201, 4-240, 4-324, 11-927, AND 94-8-105, R.C.M. 1947, AND REPEALING SECTIONS 4-164 AND 69-6202, R.C.M. 1947.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

Section 1. There is a new section to be numbered 69-6211, R.C.M. 1947, which reads as follows:

69-6211. Declaration of policy. It is the policy of the state of Montana to recognize alcoholism as an illness and that alcoholics and intoxicated persons may not be subjected to criminal prosecution because of their consumption of alcoholic beverages but rather should be afforded a continuum of treatment in order that they may lead normal lives as productive members of society.

Section 2. There is a new section to be numbered 69-6212, R.C.M. 1947, which reads as follows:

69-6212. Definitions. For purposes of this act:

(1) "alcoholic" means a person who habitually lacks self-control as to the use of alcoholic beverages, or uses alcoholic beverages to the extent that his health is substantially impaired or endangered or his social or economic function is substantially disrupted;

(2) "approved private treatment facility" means a private

agency meeting the standards prescribed in section 69-6216(1) and approved under section 69-6216;

(3) "approved public treatment facility" means a treatment agency operating under the direction and control of the department or providing treatment under this act through a contract with the department and approved under section 69-6216;

(4) "department" means the department of health and environmental sciences provided for in section 82A-601, R.C.M. 1947;

(5) "incapacitated by alcohol" means that a person, as a result of the use of alcohol, is unconscious or has his judgment otherwise so impaired that he is incapable of realizing and making a rational decision with respect to his need for treatment;

(6) "incompetent person" means a person who has been adjudged incompetent by the district court;

(7) "intoxicated person" means a person whose mental or physical functioning is substantially impaired as a result of the use of alcohol;

(8) "treatment" means the broad range of emergency, outpatient, intermediate, and inpatient services and care, including diagnostic evaluation, medical, psychiatric, psychological, and social service care, vocational rehabilitation and career counseling, which may be extended to alcoholics and intoxicated persons.

Section 3. There is a new section to be numbered 69-6213,

R.C.M. 1947, which reads as follows:

69-6213. Powers of department. The department may:

(1) plan, establish, and maintain treatment programs as necessary or desirable;

(2) coordinate its activities and cooperate with alcoholism programs in this and other states, and make contracts and other joint or cooperative arrangements with state, local, or private agencies in this and other states for the treatment of alcoholics and intoxicated persons and for the common advancement of alcoholism programs;

(3) do other acts and things necessary or convenient to execute the authority expressly granted to it; and

(4) provide treatment facilities for alcoholics and intoxicated persons.

Section 4. There is a new section to be numbered 69-6214, R.C.M. 1947, which reads as follows:

69-6214. Duties of department. The department shall:

(1) develop, encourage, and foster statewide, regional, and local plans and programs for the prevention of alcoholism and treatment of alcoholics and intoxicated persons in cooperation with public and private agencies, organizations, and individuals and provide technical assistance and consultation services for these purposes;

(2) coordinate the efforts and enlist the assistance of all public and private agencies, organizations, and individuals

interested in prevention of alcoholism and treatment of alcoholics and intoxicated persons;

(3) cooperate with the department of institutions and board of pardons in establishing and conducting programs to provide treatment for alcoholics and intoxicated persons in or on parole from penal institutions;

(4) cooperate with the department of education, the superintendent of public instruction, schools, police departments, courts, and other public and private agencies, organizations and individuals in establishing programs for the prevention of alcoholism and treatment of alcoholics and intoxicated persons, and preparing curriculum materials thereon for use at all levels of education;

(5) prepare, publish, evaluate, and disseminate educational material dealing with the nature and effects of alcohol;

(6) develop and implement, as an integral part of treatment programs, an educational program for use in the treatment of alcoholics and intoxicated persons, which program shall include the dissemination of information concerning the nature and effects of alcohol;

(7) organize and foster training programs for all persons engaged in treatment of alcoholics and intoxicated persons;

(8) sponsor and encourage research into the causes and nature of alcoholism and treatment of alcoholics and intoxicated persons, and serve as a clearing house for information relating to

alcoholism;

(9) specify uniform methods for keeping statistical information by public and private agencies, organizations, and individuals, and collect and make available relevant statistical information, including number of persons treated, frequency of admission and readmission, and frequency and duration of treatment;

(10) advise the governor in the preparation of a comprehensive plan for treatment of alcoholics and intoxicated persons for inclusion in the state's comprehensive health plan;

(11) review all state health, welfare, and treatment plans to be submitted for federal funding under federal legislation, and advise the governor on provisions to be included relating to alcoholism and intoxicated persons;

(12) assist in the development of, and cooperate with, alcohol education and treatment programs for employees of state and local governments and businesses and industries in the state;

(13) utilize the support and assistance of interested persons in the community, particularly recovered alcoholics, to encourage alcoholics voluntarily to undergo treatment;

(14) cooperate with the department of justice in establishing and conducting programs designed to deal with the problem of persons operating motor vehicles while intoxicated;

(15) encourage general hospitals and other appropriate health facilities to admit without discrimination alcoholics and

intoxicated persons and to provide them with adequate and appropriate treatment;

(16) encourage all health and disability insurance programs to include alcoholism as a covered illness; and

(17) submit to the governor an annual report covering the activities of the department.

Section 5. There is a new section to be numbered 69-6215, R.C.M. 1947, which reads as follows:

69-6215. Comprehensive program for treatment. (1) The department shall establish a comprehensive and coordinated program for the treatment of alcoholics and intoxicated persons.

(2) The program shall include:

(a) emergency treatment provided by a facility affiliated with or part of the medical service of a general hospital;

(b) inpatient treatment;

(c) intermediate treatment; and

(d) outpatient and followup treatment.

(3) The department shall provide for adequate and appropriate treatment for alcoholics and intoxicated persons admitted under sections 69-6218 to 69-6221. Treatment may not be provided at a correctional institution except for inmates.

(4) All appropriate public and private resources shall be coordinated with and utilized in the program if possible.

(5) The department shall prepare, publish, and distribute annually a list of all approved public and private treatment

facilities.

Section 6. There is a new section to be numbered 69-6216, R.C.M. 1947, which reads as follows:

69-6216. Facility standards -- inspections -- approvals. (1) The department shall establish standards for approved treatment facilities that must be met for a treatment facility to be approved as a public or private treatment facility, and fix the fees to be charged for the required inspections. The standards may concern only the health standards to be met and standards of treatment to be afforded patients.

(2) The department periodically shall inspect approved public and private treatment facilities at reasonable times and in a reasonable manner.

(3) The department shall maintain a list of approved public and private treatment facilities.

(4) Each approved public and private treatment facility shall file with the department on request, data, statistics, schedules, and information the department reasonably requires. An approved public or private treatment facility that without good cause fails to furnish any data, statistics, schedules, or information as requested, or files fraudulent returns thereof, shall be removed from the list of approved treatment facilities.

(5) The department, after holding a hearing in accordance with the Administrative Procedure Act, may suspend, revoke, limit, or restrict an approval, or refuse to grant an approval, for

failure to meet its standards.

(6) A district court may restrain any violation of this section, review any denial, restriction, or revocation of approval, and grant other relief required to enforce its provisions.

(7) Upon petition of the department and after a hearing held upon reasonable notice to the facility, a district court may issue a warrant to the department authorizing it to enter and inspect at reasonable times, and examine the books and accounts of, any approved public or private treatment facility refusing to consent to inspection or examination by the department or which the department has reasonable cause to believe is operating in violation of this act.

Section 7. There is a new section to be numbered 62-6217, R.C.M. 1947, which reads as follows:

62-6217. Acceptance for treatment; rules. The department shall adopt rules for acceptance of persons into the treatment program, considering available treatment resources and facilities, for the purpose of early and effective treatment of alcoholics and intoxicated persons. In adopting the rules the department shall be guided by the following standards:

(1) If possible a patient shall be treated on a voluntary rather than an involuntary basis.

(2) A patient shall be initially assigned or transferred to outpatient or intermediate treatment, unless he is found to

require inpatient treatment.

(3) A person shall not be denied treatment solely because he has withdrawn from treatment against medical advice on a prior occasion or because he has relapsed after earlier treatment.

(4) An individualized treatment plan shall be prepared and maintained on a current basis for each patient.

(5) Provision shall be made for a continuum of coordinated treatment services, so that a person who leaves a facility or a form of treatment will have available and utilize other appropriate treatment.

Section 8. There is a new section to be numbered 62-6218, R.C.M. 1947, which reads as follows:

62-6218. Voluntary treatment of alcoholics. (1) An alcoholic may apply for voluntary treatment directly to an approved public treatment facility. If the proposed patient is a minor or an incompetent person, he, a parent, a legal guardian, or other legal representative may make the application.

(2) Subject to rules adopted by the department, the administrator of an approved public treatment facility may determine who shall be admitted for treatment. If a person is refused admission to an approved public treatment facility, the administrator, subject to departmental rules, shall refer the person to another approved public treatment facility for treatment if possible and appropriate.

(3) If a patient receiving inpatient care leaves an approved

public treatment facility, he shall be encouraged to consent to appropriate out-patient or intermediate treatment. If it appears to the administrator of the treatment facility that the patient is an alconolic who requires help, the department shall arrange for assistance in obtaining supportive services and residential facilities.

(4) If a patient leaves an approved public treatment facility, with or against the advice of the administrator of the facility, the department shall make reasonable provisions for his transportation to another facility or to his home. If he has no home he shall be assisted in obtaining shelter. If he is a minor or an incompetent person the request for discharge from an inpatient facility shall be made by a parent, legal guardian, or other legal representative or by the minor or incompetent if he was the original applicant.

Section 9. There is a new section to be numbered 62-6219, R.C.M. 1947, which reads as follows:

62-6219. Treatment and services for intoxicated persons and persons incapacitated by alcohol. (1) An intoxicated person may come voluntarily to an approved public treatment facility for emergency treatment. A person who appears to be intoxicated in a public place and to be in need of help, if he consents to the proffered help, may be assisted to his home, an approved public treatment facility, an approved private treatment facility, or other health facility by the police.

(2) A person who appears to be incapacitated by alcohol shall be taken into protective custody by the police and forthwith brought to an approved public treatment facility for emergency treatment. If no approved public treatment facility is readily available he shall be taken to an emergency medical service customarily used for incapacitated persons. The police, in detaining the person and in taking him to an approved public treatment facility, is taking him into protective custody and shall make every reasonable effort to protect his health and safety. In taking the person into protective custody, the detaining officer may take reasonable steps to protect himself. No entry or other record may be made to indicate that the person taken into custody under this section has been arrested or charged with a crime.

(3) A person who comes voluntarily or is brought to an approved public treatment facility shall be examined by a licensed physician as soon as possible. He may then be admitted as a patient or referred to another health facility. The referring approved public treatment facility shall arrange for his transportation.

(4) A person who by medical examination is found to be incapacitated by alcohol at the time of his admission or to have become incapacitated at any time after his admission, may not be detained at the facility (1) once he is no longer incapacitated by alcohol, or (2) if he remains incapacitated by alcohol for more

than forty-eight (48) hours after admission as a patient, unless he is committed under section 69-6220. A person may consent to remain in the facility as long as the physician in charge believes appropriate.

(5) A person who is not admitted to an approved public treatment facility and is not referred to another health facility, may be taken to his home. If he has no home, the approved public treatment facility shall assist him in obtaining shelter.

(6) If a patient is admitted to an approved public treatment facility, his family or next of kin shall be notified as promptly as possible. If an adult patient who is not incapacitated requests that there be no notification, his request shall be respected.

Section 10. There is a new section to be numbered 69-6220, R.C.M. 1947, which reads as follows:

69-6220. Emergency commitment. (1) An intoxicated person who (a) has threatened, attempted, or inflicted physical harm on another and is likely to inflict physical harm on another unless committed, or (b) is incapacitated by alcohol, may be committed to an approved public treatment facility for emergency treatment. A refusal to undergo treatment does not constitute evidence of lack of judgment as to the need for treatment.

(2) The certifying physician, spouse, guardian, or relative of the person to be committed, or any other responsible person, may make a written application for commitment under this section,

directed to the administrator of the approved public treatment facility. The application shall state facts to support the need for emergency treatment and be accompanied by a physician's certificate stating that he has examined the person sought to be committed within two (2) days before the certificate's date and facts supporting the need for emergency treatment. A physician employed by the admitting facility or the department is not eligible to be the certifying physician.

(3) Upon approval of the application by the administrator of the approved public treatment facility, the person shall be brought to the facility by a peace officer, health officer, the applicant for commitment, the patient's spouse, the patient's guardian, or any other interested person. The person shall be retained at the facility to which he was admitted, or transferred to another appropriate public or private treatment facility, until discharged under subsection (5).

(4) The administrator of an approved public treatment facility shall refuse an application if in his opinion the application and certificate fail to sustain the grounds for commitment.

(5) When on the advice of the medical staff the administrator determines that the grounds for commitment no longer exist, he shall discharge a person committed under this section. No person committed under this section may be detained in any treatment facility for more than five (5) days. If a petition for

involuntary commitment under section 69-6221 has been filed within the five (5) days and the administrator in charge of an approved public treatment facility finds that grounds for emergency commitment still exist, he may detain the person until the petition has been heard and determined, but no longer than ten (10) days after filing the petition.

(6) A copy of the written application for commitment and of the physician's certificate, and a written explanation of the person's right to counsel, shall be given to the person within twenty-four (24) hours after commitment by the department, who shall provide a reasonable opportunity for the person to consult counsel.

Section 11. There is a new section to be numbered 69-6221, R.C.M. 1947, which reads as follows:

69-6221. Involuntary commitment of alcoholics. (1) A person may be committed to the custody of the department of institutions by the district court upon the petition of his spouse or guardian, a relative, the certifying physician, or the chief of any approved public treatment facility. The petition shall allege that the person is an alcoholic who habitually lacks self-control as to the use of alcoholic beverages and that he (a) has threatened, attempted, or inflicted physical harm on another and that unless committed is likely to inflict physical harm on another; or (b) is incapacitated by alcohol. A refusal to undergo treatment does not constitute evidence of lack of judgment as to

the need for treatment. The petition shall be accompanied by a certificate of a licensed physician who has examined the person within two (2) days before submission of the petition, unless the person whose commitment is sought has refused to submit to a medical examination, in which case the fact of refusal shall be alleged in the petition. The certificate shall set forth the physician's findings in support of the allegations of the petition. A physician employed by the admitting facility or the department is not eligible to be the certifying physician.

(2) Upon filing the petition, the court shall fix a date for a hearing no later than ten (10) days after the date the petition was filed. A copy of the petition and of the notice of the hearing, including the date fixed by the court, shall be served on the petitioner, the person whose commitment is sought, his next of kin other than the petitioner, a parent or his legal guardian if he is a minor, the administrator in charge of the approved public treatment facility to which he has been committed for emergency care, and any other person the court believes advisable. A copy of the petition and certificate shall be delivered to each person notified.

(3) At the hearing the court shall hear all relevant testimony, including, if possible, the testimony of at least one licensed physician who has examined the person whose commitment is sought. The person shall have a right to have a licensed physician of his own choosing examine him and testify on his

behalf, and if he has no funds with which to pay such physician, the reasonable costs of one such examination and testimony shall be paid by the county. The person shall be present unless the court believes that his presence is likely to be injurious to him; he shall be advised of his right to counsel and, if he is unable to hire his own counsel, the court shall appoint an attorney to represent him at the expense of the county. The court shall examine the person in open court, or if advisable, shall examine the person in chambers. If he refuses an examination by a licensed physician and there is sufficient evidence to believe that the allegations of the petition are true, or if the court believes that more medical evidence is necessary, the court may make a temporary order committing him to the department of institutions for a period of not more than five (5) days for purposes of a diagnostic examination.

(4) If after hearing all relevant evidence, including the results of any diagnostic examination by the department of institutions, the court finds that grounds for involuntary commitment have been established by clear and convincing evidence, it shall make an order of commitment to the department of institutions. It may not order commitment of a person unless it determines that the department of institutions is able to provide adequate and appropriate treatment for him and the treatment is likely to be beneficial.

(5) A person committed under this section shall remain in

the custody of the department of institutions for treatment for a period of thirty (30) days unless sooner discharged. At the end of the thirty (30) day period, he shall be discharged automatically unless the department of institutions before expiration of the period obtains a court order from the district court of the committing district for his recommitment upon the grounds set forth in subsection (1) for a further period of ninety (90) days unless sooner discharged. If a person has been committed because he is an alcoholic likely to inflict physical harm on another, the department of institutions shall apply for recommitment if after examination it is determined that the likelihood still exists.

(6) A person recommitted under subsection (5) who has not been discharged by the department of institutions before the end of the ninety (90) day period shall be discharged at the expiration of that period unless the department of institutions, before expiration of the period, obtains a court order from the district court of the committing district on the grounds set forth in subsection (1) for recommitment for a further period not to exceed ninety (90) days. If a person has been committed because he is an alcoholic likely to inflict physical harm on another, the department shall apply for recommitment if after examination it is determined that the likelihood still exists. Only two (2) recommitment orders under subsections (5) and (6) are permitted.

(7) Upon the filing of a petition for recommitment under

subsections (5) or (6), the court shall fix a date for hearing no later than ten (10) days after the date the petition was filed. A copy of the petition and of the notice of hearing, including the date fixed by the court, shall be served on the petitioner, the person whose commitment is sought, his next of kin other than the petitioner, the original petitioner under subsection (1) if different from the petitioner for recommitment, one of his parents or his legal guardian if he is a minor, and any other person the court believes advisable. At the hearing the court shall proceed as provided in subsection (3).

(8) A person committed to the custody of the department of institutions for treatment shall be discharged at any time before the end of the period for which he has been committed if either of the following conditions is met:

(a) in case of an alcoholic committed on the grounds of likelihood of infliction of physical harm upon another, that he is no longer in need of treatment or the likelihood no longer exists; or

(b) in case of an alcoholic committed on the grounds of the need of treatment and incapacity, that the incapacity no longer exists, further treatment will not be likely to bring about significant improvement in the person's condition, or treatment is no longer adequate or appropriate.

(9) The court shall inform the person whose commitment or recommitment is sought of his right to contest the application, be

represented by counsel at every stage of any proceedings relating to his commitment and recommitment, and have counsel appointed by the court or provided by the court, if he wants the assistance of counsel and is unable to obtain counsel. If the court believes that the person needs the assistance of counsel, the court shall require, by appointment if necessary, counsel for him regardless of his wishes. The person whose commitment or recommitment is sought shall be informed of his right to be examined by a licensed physician of his choice. If the person is unable to obtain a licensed physician and requests examination by a physician, the court shall employ a licensed physician.

(10) If a private treatment facility agrees with the request of a competent patient or his parent, sibling, adult child, or guardian to accept the patient for treatment, the department of institutions may transfer him to the private treatment facility.

(11) A person committed under this section may at any time seek to be discharged from commitment by writ of habeas corpus or other appropriate means.

(12) The venue for proceedings under this section is the place in which person to be committed resides or is present.

Section 12. There is a new section to be numbered 69-6222, R.C.M. 1947, which reads as follows:

69-6222. Records of alcoholics and intoxicated persons. (1) The registration and other records of treatment facilities shall remain confidential and are privileged to the patient.

(2) Notwithstanding subsection (1), the department may make available information from patients' records for purposes of research into the causes and treatment of alcoholism. Information under this subsection shall not be published in a way that discloses patients' names or other identifying information.

Section 13. There is a new section to be numbered 69-6223, R.C.M. 1947, which reads as follows:

69-6223. Visitation and communication of patients. (1) Subject to reasonable rules regarding hours of visitation which the department may adopt, patients in any approved treatment facility shall be granted opportunities for adequate consultation with counsel, and for continuing contact with family and friends consistent with an effective treatment program.

(2) Neither mail nor other communication to or from a patient in any approved treatment facility may be intercepted, read, or censored. The administrator may adopt reasonable rules regarding the use of telephone by patients in approved treatment facilities.

Section 14. There is a new section to be numbered 69-6224, R.C.M. 1947, which reads as follows:

69-6224. Application of Administrative Procedure Act. The Administrative Procedure Act applies to and governs all administrative actions taken under this act.

Section 15. Section 4-201, R.C.M. 1947, is amended to read as follows:

"4-201. Interdiction -- order of -- effect. (1) Where it appears to the satisfaction of a district court that an individual lacks self-control as to the use of alcoholic beverages, or uses alcoholic beverages to the extent that his health is substantially impaired or endangered or his social or economic function is substantially disrupted, the court may make an order of interdiction prohibiting the sale of liquor to him until further order; and the court shall cause the order to be forthwith filed with the department of revenue.

(2) On the making of an order for interdiction the interdicted person may forthwith deliver to the department all liquor then in his possession or under his control to be kept for him by the board until the order of interdiction is revoked or set aside, or to be purchased by the department at a price to be fixed by it. All liquor not delivered to the department under this subsection may be confiscated and forfeited to the state."

Section 16. Section 11-927, R.C.M. 1947, is amended to read as follows:

"11-927. Prevention of and punishment for disturbing the peace. The city or town council has power: To prevent and punish intoxication (subject to the limits established in section 69-6224), fights, riots, loud noises, disorderly conduct, obscenity, and acts or conduct calculated to disturb the public peace, or which are offensive to public morals, within the city or town, and within three miles of the limits thereof."

Section 17. Section 4-240, R.C.M. 1947, is amended to read as follows:

"4-240. License tax on liquor -- amount -- distribution of proceeds. The department of revenue is hereby authorized and directed to charge, receive and collect at the time of sale and delivery of any liquor under any provisions of the laws of the state of Montana a license tax of five percent (5%) of the retail selling price on all liquor so sold and delivered. Said tax shall be charged and collected on all liquor brought into the state and taxed by the department of revenue. The retail selling price shall be computed by adding to the cost of said liquor the state markup as designated by said board. Said five percent (5%) license tax shall be figured in the same manner as the state excise tax and shall be in addition to said state excise tax. The department of revenue shall retain the amount of such five percent (5%) license tax so received in a separate account. Four-fifths (4/5) of these revenues shall be distributed to the counties according to the amount of liquor purchased in each county. One-fifth (1/5) of these revenues shall be deposited in the general fund. Provided, however, in the case of purchases of liquor by a retail liquor licensee for use in his business, the department shall make such regulations as are necessary to apportion that proportion of license tax so generated to the county where the licensed establishment is located, for use as provided in section 4-241, R.C.M. 1947. The department of

revenue shall pay quarterly to each county treasurer the proportion of the license tax due each county.

The county treasurer of each county shall retain one-fourth (1/4) of said license tax, and shall, within thirty (30) days after receipt thereof, apportion the remaining three-fourths (3/4) thereof to the treasurers of the incorporated cities and towns within his county, said apportionment to be based in each instance upon the proportion which the gross sale of liquor in such incorporated city or town bears to the gross sale of liquor in all of the incorporated cities and towns in his said county."

Section 18. Section 4-324, R.C.M. 1947, is amended to read as follows:

"4-324. Tax on imported beer -- computation in case of barrels of capacity other than thirty-one gallons. A tax of three dollars ($3) per barrel of thirty-one (31) gallons, is hereby levied and imposed on each and every barrel of beer manufactured out of this state and sold herein by any wholesaler, which said tax shall be due at the end of each month from said wholesaler, upon any such beer so sold by him during that month. As to any beer imported and sold in containers other than barrels, or in barrels of more or less capacity than thirty-one (31) gallons, the quantity content shall be ascertained and computed by the department of revenue in determining the amount of tax due, as herein provided for. An additional tax of twenty-five cents ($.25) per barrel is levied and imposed as provided by this

section, and such additional tax is also to be levied and imposed at the same rate upon beer manufactured within the state. The additional tax of twenty-five cents ($.25) is to be deposited, notwithstanding sections 4-347, 4-347.1, or any other provision, in the general fund."

Section 19. There is a new section to be numbered 69-6224, R.C.M. 1947, which reads as follows:

69-6224. Departmental reports to legislature. The department and the department of institutions shall achieve full implementation of the provisions of the act, as set forth in this chapter and related sections, no later than January 1, 1976. A progress report on the implementation shall be made to the 1975 legislative session. Thereafter the departments shall report, to each legislative session, on the status of the implemented act. This report, or any part thereof, may be included as the department's state plan for alcohol abuse and alcoholism.

Section 20. Sections 4-164 and 69-6202, R.C.M. 1947, are repealed.

I hereby certify that the within bill originated in the House.

Chief Clerk

Speaker of the House
Signed this 16th day
of March, 1974.

President of the Senate
Signed this 16th day
of March, 1974.

Part IV Narrative of the program proposed to implement the Montana Uniform Act.

1. The history of the Montana Uniform Act is brief as the Act has only been in effect for approximately ten months. The Act became law on July 1, 1975. The efforts to implement the Act have been local and have lacked the coordination that is proposed to be done with the incentive grant. The alcohol service providers from throughout the State have a working knowledge of the provisions presented in the Act and have made some effort toward full implementation, however, the State Office has not been able to provide the necessary support to the law enforcement agencies and the medical community.

2. Montana considers a new law implemented when the Rule to implement has been accepted into the Administrative Procedures Act. This has been accomplished. From a functional viewpoint, little has actually been accomplished in the full implementation of this Act on a statewide basis. The effort to implement has varied from community to community. The alcohol service providers in the sparsely populated eastern portion of the State have been successful in bringing about a concerted effort to meet the philosophical goals of the Act. Both law enforcement and the hospitals in that geographical area seem to understand the Act and have cooperative efforts working. The City of Billings has deomonstrated a high degree of interest in the Act and has made significant efforts to implement it. The Billings Deaconess Hospital and the Rimrock

Guidance Foundation have established a detoxification unit in a building adjacent to the hospital and have a comprehensive range of services available to the detoxification clients. A DWI court referral program is also tied into the total structure. State funds have gone into this operation and the hospital has used a substantial amount of its own money. This project had the potential for being a model to be observed by other communities. The service has worked well but the hospital is viewing the effort as a financial disaster and other hospitals are picking up on this negative result. The results of implementation efforts in other communities are less well defined, both in terms of the service provided and the cost factor. The service providers and the services they provide are listed in the following material.

MONTANA STATE PLAN FY 76

CURRENT ALCOHOLISM SERVICES IN THE MENTAL HEALTH REGIONS

REGION I

COUNCIL OF COUNTIES - District I - This group of 5 counties provide referral and outpatient counseling services. They are operating on $40,829 from the SAA and revenue sharing funds from the participating counties. The service area is the 5 counties in the northeast corner of the State.

COUNCIL OF COUNTIES - District II - This is a group of four counties in the eastern central portion of the state. They provide referral and outpatient counseling. Their funding from the SAA is $28,200 with additional funds from county revenue sharing from the four counties.

FORT PECK RESERVATION ALCOHOLISM PROGRAM - This program serves the reservation Indians at Poplar. A comprehensive range of service if offered, which includes detoxification, intermediate care, counseling, outreach, prevention, thrift shop, information and referral. Sources of funding include: IHS - $68,200, NIAAA -$33,200 and supplemental NIAAA - $24,000. The total level of funding is $125,400.

REGION I (continued)

COLSTRIP YOUTH PROJECT - This program located in the high impact coal area of southeastern Montana provides referral and outpatient counseling to high school age youth. It is funded with county revenue sharing funds, NIDA funds through the SDA, Voc Rehab and $9,750 from the SAA. Service area is primarily the town of Colstrip.

CUSTER COUNTY - The County Health Department operates a referral and outpatient counseling service. This county program has received $9,500 from the SAA and has additional funds from county revenue sharing. The service area is Custer County.

NORTHERN CHEYENNE ALCOHOLISM PROGRAM - This program serves the reservation Indians of Lame Deer. A comprehensive range of service is offered which includes: detox, intermediate care, counseling, outreach, information and referral. The sources of funding are: IHS - $37,800 and NIAAA - $54,000. The total level of funding is $91,800.

ROSEBUD COUNTY - The County Health Department operates a referral and outpatient counseling service. They are receiving $4,636 from the SAA and also utilize county revenue sharing. The service area is the county.

REGION II

GREAT FALLS - The City-County Health Department operates a comprehensive range of services. This includes intermediate care, inpatient treatment, outpatient, follow-up, education and prevention. Detox is available on a limited basis. These services are provided on a contractual arrangement. This community program received $148,529 in funding from the State Alcohol Authority. They also have additional funding from City and County revenue sharing, Vocational Rehabilitation fees for service. They serve primarily the residents of Cascade County.

HILLTOP RECOVERY CENTER - Havre - This program provides detox, inpatient treatment, intermediate, outpatient, referral education and prevention for seven counties in the North Central portion of the State. They have received $54,700 from the SAA and receive revenue sharing funds from each of the seven counties served. In addition, they have some United Givers and City revenue sharing funds and fees for service.

FORT BELKNAP ALCOHOLISM PROGRAM - This program serves the reservation Indians at Harlem. A comprehensive range of service is offered which includes detoxification at the Indian Health Hospital, intermediate care, counseling, information and referral. The sources of funding are: IHS - $45,280 and NIAAA - $42,964. The total level of funding is $88,244.

REGION II (continued)

ROCKY BOY ALCOHOLISM PROGRAM - This program serves the reservation Indians at Box Elder. A comprehensive range of service is offered, which includes detoxification, intermediate care, counseling, information and referral. The sources of funding are: IHS - $33,600 and NIAAA - $30,000. The total level of funding is $63,600.

BLACKFEET ALCOHOLISM PROGRAM - This program serves the reservation Indians at Browning. A comprehensive range of service is offered, including detox, outpatient, counseling, prevention, rehabilitation, information and referral. The sources of funding are: IHS - $47,000 and NIAAA - $40,000. Total level of funding - $87,700.

REGION III

BILLINGS - The Rimrock Guidance Foundation is the agency providing alcohol services. This agency provides detox services through a contract with the Deaconess Hospital. Rimrock provides intermediate care for both male and female, outpatient, follow up, education, prevention and referral. In patient treatment capability is being developed and will be operational soon. This program received $42,656 from the SAA for the current fiscal year. They also receive a significant amount of funding from the United Givers and from client fees.

REGION III (continued)

CROW RESERVATION ALCOHOLISM PROGRAM - This program serves the reservation Indians at Crow Agency. A comprehensive range of service is offered, which includes: detoxification, counseling, information and referral. The sources of funding are: IHS - $47,400 and NIAAA - $30,000. The total level of funding is $77,400.

ALCOHOL REHABILITATION ASSOCIATION - Helena - This program provides detox, outpatient counseling, referral, education and prevention in ten Southwestern Montana counties. They are funded with a Federal Staffing grant, County revenue sharing, United Givers, Voc. Rehab. and $60,609 from the SAA.

GALEN ALCOHOL TREATMENT CENTER - This program is State operated and provides detox and inpatient treatment for residents of the State.

FRONTIER ALCOHOLISM PROGRAM - Dillon - This program provides detox, referral and outpatient counseling for the residents of Beaverhead County. It is funded with County and City revenue sharing funds and $30,000 from the SAA.

NORTH AMERICAN INDIAN ALLIANCE - This program serves the urban Indians within the City of Butte. Services offered include information and referral, education and counseling (individual and family). The source of funding is NIAAA - $42,328.

REGION IV (continued)

DEER LODGE COUNTY - This county program provides referral and outpatient counseling for the residents of Anaconda and the county. It is funded with county revenue sharing money and $15,795 from the SAA.

BOYD ANDREWS' GUEST HOUSE - Helena - This is a twelve step house providing residence for five clients. They provide referral and counseling.

REGION V

NORTHWEST MONTANA ALCOHOL PROGRAM - Kalispell - This program serves Flathead and Lincoln counties, provides referral, outpatient counseling, education and prevention. They have been funded with $42,411 from the SAA and also have county revenue sharing, united givers, fees for service, Vocational Rehabilitation and CETA.

FLATHEAD ALCOHOLISM & DRUG ABUSE PROGRAM - This program serves the reservation Indians at Ronan. They also operate an information and referral service in Sanders County. A comprehensive range of service is offered, which includes detox, intermediate care, counseling, outreach, follow-up, prevention, education, information and referral. The tribe recently donated a new building to house the program's detox and intermediate care components. Sources of

REGION V (continued)

funding include: IHS - $50,728, NIAAA -$29,000 and NIAA - $135,000. The total level of funding is $214,728.

MISSOULA INDIAN ALCOHOL & DRUG SERVICES - This program serves urban Indians within the City of Missoula. Services offered include information, referral and counseling. The source of funding is NIAAA - $64,000.

Two urban Indian alcohol programs have been approved for funding, but the monies have not been awarded. They are BILAMIWCO in Billings and the Indian Education Center in Great Falls.

The Montana Indian Commission on Alcohol and Drug Abuse had their federal funding discontinued.

No determination can be made, at this time, as to the effectiveness of these services listed, however, Montana has been awarded a grant by the Council of State and Territorial Alcohol Authorities to develop an evaluation system that will help with future assessments.

Montana has appropriated approximately $500,000 to implement the Uniform Act during FY '76 and a similar appropriation for FY '76. The FY '76 State funds were contracted with service providers in the following amounts:

Action for Eastern Montana	$ 240.66	staff training
City/County Health Dept. - Great Falls	148,529.10	client service
Custer County	9,500.00	client service
Rimrock Guidance - Billings	42,646.00	client service
Council of Counties - District I	40,829.00	client service
Council of Counties - District II	28,200.00	client service
Rosebud County	4,636.48	client service
N.W. Montana Alcohol Program - Kalispell	42,411.00	client service
Hill-Top Recovery - Havre	54,700.00	client service
ARA - Helena	60,609.77	client service
City/County - Great Falls	755.00	staff training
Colstrip Youth Project	9,750.00	client service
Frontier - Dillon	30,000.00	client service
Deer Lodge County	15,795.00	client service
Total	$488,602.01	

No other funds, specifically for implementation of the Uniform Act, have been available.

Law enforcement has mixed reactions to the Act, both positive and negative. Some law enforcement agencies, particularly in the Eastern portion of the State have made productive efforts to be involved in the partnership to implement the intent of the Act, however, the law enforcement lobby groups opposed the Act during its passage and have indicated that even stronger opposition will be forthcoming during the next legislative session.

3. The specific project plan will bring about the full range of benefits stated in the Uniform Act (comprehensive services available on a statewide basis) through five measurable objectives. These objectives are listed on the following pages.

State Montana

Name

Date

Element

TASK #	PRODUCT	TARGET DATE	RESOURCES COSTS	RESOURCES FUNDING SOURCES	COMMENTS (CONSTRAINTS)
Objective #1 . training at approved educational institutions for alcohol service providers (existing and future community staff)	continuous upgrading of the quality of service provided to alcoholism clients.	9/1/76 through 8/30/77	35,589	NIAAA	
Objective #2 workshop for state level law enforcement agencies	better understanding by law enforcement policy makers of Uniform Act intent and philosophical considerations.	by 10/15/76	5,613	NIAAA	
Objective #3 workshop for state level medical and hospital policy makers	better understanding by medical and hospital policy makers of Uniform Act intent and philosophical considerations.	by 10/15/76	5,613	NIAAA	

State Montana

Name

Date

Element

TASK #	PRODUCT	TARGET DATE	RESOURCES COSTS	RESOURCES FUNDING SOURCES	COMMENTS (CONSTRAINTS)
Objective #4 Workshop forlocal law enforcement Chiefs, Sargents, etc.	Better understanding of their role in dealing with the public intoxicant	11/15/76	5,613	NIAAA	
Objective #5					
Workshop for local Doctors and hospital administrators	Better understanding of their role in accepting, treating and referring intoxicated persons	11/15/76	5,613	NIAAA	

SECTION 13

13.1 CORRESPONDENCE RELATED TO FY 75 STATE ALCOHOLISM PLAN

Department of Institutions

BOARD MEMBERS
ZELLA A. JACOBSON, GREAT FALLS
ELDON E. KNOWLES, BILLINGS
WILLIS M. NORTON, MISSOULA
ROBERT J. PALLO, HAVRE
JOHN W. STRICH, M.D., HELENA

MONTANA STATE PLAN FY 76
Helena, 59601

January 30, 1976

Ms. Naomi Kennedy
Rm. 11037, Federal Office Bldg.
1961 Stout St.
Denver, Colorado 80202

Dear Naomi:

Hiliary H. Connor, MD., Regional Health Administrator, Alcohol, Drugs and Mental Health Administration submitted a letter to John S. Anderson, MD., Director, Montana Department of Health and Environmental Sciences, outlining a series of five special conditions to be met before the Federal Alcohol Formula funds for FY'75 could be expended.

This will be a detailed response to each of those conditions. Each condition will be listed and the response dealing with that particular condition will follow.

Condition #1. "Written clarification by the Governor as to the current designation of the Single State Authority; the structure and membership of the Advisory Council; the role and functions of the Council; and a definition of administration perogratives."

Response to Condition #1

Governor Thomas L. Judge has designated the Department of Institutions as the Single State Authority for Alcohol and Drugs as mandated in House Bill 699, Chapter 280, Session Laws 1975. (Exhibit A, copy of House Bill 699 as signed by the Governor and filed with the Secretary of State. Exhibit B, letter from Governor Thomas L. Judge to Dr. Robert H. Mattson designating the Department of Institutions as the State Department of government to serve as the Single State Authority for Alcohol and Drugs.)

The Advisory Council was transferred from the Department of Health and Environmental Sciences to the Department of Institutions and the membership was amended as of September 12, 1975. This is the date that Governor Thomas L. Judge approved the transfer and the membership amendment and filed the document with the Secretary of State. (Exhibit C, copy of that document.)

MONTANA STATE PLAN FY 76

The membership of the Advisory Council consists of the following members: Carl Kip, Browning; Sharon Pettit, Helena; Peggy Skelton, Missoula; Robert L. VanHorne, Missoula; Larry Fasbender, Fort Shaw; Katherine A. Hanrahan, Glendive; Gerald B. Hall, Great Falls; Martha L. Herlevi, Red Lodge. All of these members have served on the Advisory Council previously with the exception of Carl Kip.

The following policies and procedures outline the intended functions of the Advisory Council:

To advise the State Alcohol and Drug Authority (Director or his designee, Department of Institutions) on alcohol and drug matters. (Exhibit D, By-Laws).

1. To review and advise the Department on policy development as it relates to criteria for the utilization of formula grant funds (Public Law 91-616, Section 303 and Public Law 92-255, Section 409) and the utilization of State funds intended for alcohol and drug programs.

2. To advise the Department, at its request, on matters of specific need assessments of alcohol and drug programming.

3. To provide an overall analysis on an annual basis, of alcohol and drug program activity. The evaluation task will consist of measuring the accomplishment of the State programs goal and objectives, and making recommendations to the Department for future statewide direction in alcohol and drug program activity. The evaluation function will be restricted to an analysis of overall program activities and the making of recommendations to the Department.

4. To provide a review of advisory function at the request of the Department, for the hearing of grievence matters from local alcohol and drug programs.

Condition #2. "Evaluation and accountability rely upon the assessment of quantity and quality of services provided. An unduplicated account of individuals served and a plan for statewide evaluation of the quality of services is needed."

Response to Condition #2

The determination of quality of service provided in Montana is being addressed through the rule developed to implement the recently passed Uniform Alcoholism and Intoxication Treatment Act. (Rule enclosed as Exhibit E.) The rule for implementation of this Act was developed to move the quality of programs in the direction of accreditation by the Joint Commission on Accreditation of Hospitals, which is the National body determining quality of services throughout the country. Programs meeting the conditions of the rule for implementation of this law will be approved by the Department of Institutions. Programs not meeting these conditions will be given written statements outlining the specific deficiency.

The quantity of alcoholism services provided in Montana is determined by two methods. The first is a monthly data format that is being completed by each program operating alcoholism services in the State. This monthly data summary requests information concerning the number of clients being served, the number of new clients, the number of repeaters, the referral sources, the age, the income level, and the employment status of all clients. The Montana Alcoholism Programs have been submitting these data summaries on a monthly basis for approximately 20 months. These monthly data summaries are being held, at this time, for inclusion in the Department of Institutions Data Collecting System. (A copy of the data summary form is included as exhibit F.) On January 6, 1976, the Montana State Department of Institutions submitted, to the Council of State and Territorial Alcohol Authorities, a proposal in response to RFP CSTAA 75-02 a request for funding to develop an alcoholism program management information system. (Proposal included as exhibit G.)

An unduplicated count of clients receiving services in Montana on a given day was conducted on July 14, 1975. Each program was asked to provide a count, by category, of their active case load and efforts were made in conducting the survey to eliminate any duplication of client count. Clients being served by category were as follows as of July 14, 1975:

Type of Service	
In Patient	144
Out Patient	927
Aftercare	697
Intermediate Care	111
Detoxification	57
Driving while Intoxicated Program	68
Other	120
Total	2154

Condition #3. "Criteria should be developed and utilized in the awarding of all formula grant funds for treatment and rehabilitation services which is consistent with stated priorities, goals and objectives."

Response to Condition #3

Montana legislation which enacted the Uniform Alcoholism Intoxication and Treatment Act, mandates, by statute, that every Montana community have the capability of providing a wide range of services for those incapacitated by alcohol. This capability currently exists in only a few Montana communities.

The passage of the Uniform Alcoholism and Intoxication Treatment Act by the Montana Legislature is a major breakthrough in the structure and delivery of services to alcoholics and alcohol abusers. Through

the implementation of this Act, on a statewide basis, the stated goals as listed in the first State Plan will become a reality.

The full attainment of these goals will be accomplished through a de-centralized plan that reflects a committment to integrate programming into regional health and political systems. Responsibility for leadership for alcoholism programming will be vested in the local community. Local concerns indiginious approaches for the control of alcoholism and involvement of community agencies will result in county programs which will differ from each other. Although the local programs will differ, the goals and objectives are uniformly defined in the Uniform Alcoholism and Intoxication Act. This decentralization and ultimate establishment of a wide range of services for each community will be accomplished through a full utilization of the existing Mental Health Regional Boards.

Each Regional Mental Health Board will serve as the contract entity between the Department of Institutions, Addictive Diseases Division and the community with the Board itself operating a program directly or contracting it out to an alcoholism council, general hospital or some other local agency.

Condition #4. "Indication of a budget plan for state funds with relation to priorities, goals and objectives is needed. Also a budget plan for other federal funds, if any."

Response to Condition #4

The budget for the allocation of FY 75 formula funds of $200,000 would be in the following manner:

The State is divided into five Mental Health Regions. Each Region has a Mental Health Board. It is our intent to fund each of the five Mental Health Boards with $20,000 of formula funds. Each Board will then hire a Resource Development person. This person will generally coordinate alcohol with community based alcohol and related programs and serve as an advocate for alcohol programming in each of the Regions. In addition, $20,000 will be available to general hospitals in each Region to be used as fees for services provided to individuals needing care as the consequence of alcoholism addiction. Also, some funds may be used for staff and agency training.

Condition #5. "Submission of 4 copies of the complete plan following the format contained in the NIAAA draft guidelines for state assistance grants, dated February 4, 1973. Copies should include a copy of all assurance and all other requirements such as A-95 certification and proof of publication."

Response to Condition #5

Four copies of the completed plan will be forwarded for Regional

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Office use and approval. The assurances referred to in Condition #5 have already been met in full and are included in the original State Plan that was submitted to the Regional Office for review on April 17, 1975. (Exhibit H, A-95 Sign-off, Exhibit I, copy of newspaper legal ads.)

The above material addresses all of the questions raised by Dr. Conner in his letter of June 2, 1975. Please let me know if you have any questions.

Sincerely yours,

Dr. Robert H. Mattson by:
Michael A. Murray

Robert H. Mattson, Ed.D.
Director

encl.

RHM:MM:bg

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
REGION VIII
FEDERAL OFFICE BUILDING
19TH AND STOUT STREETS
DENVER COLORADO 80202

March 9, 1976

RECEIVED
PUBLIC HEALTH SERVICE
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION
DEPARTMENT OF INSTITUTIONS

Robert H. Mattson, Ed.D.
Director
Montana State Dept. of Institutions
1539 11th Avenue
Helena, Montana 59601

Re: Montana State Plan for Alcoholism and Alcohol Abuse FY 75-76

Dear Dr. Mattson:

It seems necessary to request the long form as a complete plan for this fiscal year (1976) for meeting all requirements of NIAAA. Following is the rationale for the request: (1) Newness of the present Alcohol Authority with new leadership, philosophy, and the new functional organizational structure; (2) The stage of development in alcohol programming in Montana; (3) The ADAMHB Regional Office expectations cited in the recent FY 74-75 approval letter dated March 3, 1976, and; (4) Provision of an opportunity for Montana to reflect the continuing evolutional aspects of the recent shifts toward decentralization to five Regional Boards.

A short guide as to what will be expected follows:

(1) An action plan for fiscal year 1976 reflecting anticipated gains in alcohol program development in the various regions in the State and reflecting the goals and activities involving the State agency staff.

(2) Changes in program plan, major staff changes, new organizational chart and changes in the composition of membership on the advisory council should be reported.

(3) Budget should be included.

(4) The action plan of the State agency should reflect the evaluation activity within the State and the specific plans or activities in monitoring and evaluation that will be undertaken.

(5) Site assessments - Will State staff accompany site assessors contracted for by NIAAA to do site assessments to recipients of project awards? Will State staff accompany State mental health staff and Regional Office ADAMHB staff on their visits to Comprehensive Community Mental Health Centers?

AMERICAN REVOLUTION BICENTENNIAL 1776-1976

(6) Other NIAAA funds - How will the State agency make application kits for NIAAA funds (it is taken for granted that State staff will be involved with formula grant funds - this refers to other than formula funds) available to potential applicants? Will State staff review and comment on each application for NIAAA funds (other than formula funds)?

(7) Prevention - What activities will be undertaken, evaluated, and monitored by State agency staff? What is the priority for prevention?

(8) Minorities - How is minority input into the State Plan achieved? Will the needs of the minorities (American Indians, in particular) be met?

This is a very important item to address in fiscal year 1976 plan in view of the decentralization to five "mental health" regions, Mental Health CMH Centers are expected to address relationships. provision of service, etc., to on and off reservation Indians. Originally Alcohol planned the scattered Indian reservations as the 6th Montana region. What is the plan regarding this minority now and in the future?

(9) Advisory Council - Does the present council membership meet requirements in terms of minorities and nonprovider members?

(10) Uniform Act - What is the State's planning re: incentive awards for implementation of the Uniform Act?

(11) Occupational Alcoholism Activities - What activities will State staff undertake? How are those activities monitored and evaluated?

(12) Statistical Information - What is currently being generated (sample statistical reports may be included as appendices). Does the State have a plan for further developing statistical information.

Enclosed are copies of:

1. Nov. 21, 1974 letter from Lois Whitley to Robert Solomon.
2. Procedure for Review of Alcoholism Plans.
3. Table of Contents.

The above may be of some assistance to staff as the 1976 plan is pulled together.

Should there be questions about this letter or the Plan, please do not hesitate to contact the ADAMH Branch Office. The 1976 Plan is due April 1st, or as soon as possible thereafter for review and processing.

Sincerely,

A. Naomi Kennedy
Regional Consultant for Mental Health

Enclosures (3)
cc: Mike Murray and T. Fasso

Mr. Robert Solem, Administrator
Alcohol Services Division
Montana Department of Health
and Environmental Sciences
Cogswell Building
Helena, Montana 59601

Dear Bob:

Last week when I attended the quarterly meeting for Regional Consultants in Alcoholism in Rockville, Claude Reeder gave us a report on the new requirements of P.L. 93-282 for the formula grant program. Claude stated that even though we do not have regulations for P.L. 93-282, nor have the guidelines been revised to reflect the provisions in question, the law is in effect and the States have to address the changes using the law as a guide. The provisions referred to are as follows:

1. That the advisory council shall include representatives "of groups to be served with attention to assuring representation of minority and poverty groups."

2. That the State plan shall "set forth, in accordance with criteria to be set by the Secretary, standards (including enforcement procedures and penalties) for (A) construction and licensing of public and private treatment facilities, and (B) for other community services or resources available to assist individuals to meet problems resulting from alcohol abuse."

The regulations governing the formula grant program should be published in the near future, at which time the guidelines will be revised to [illegible] and the grant forms. However, since [illegible] will not be available to you before you complete work on your FY 76 plan, I will provide you with some instructions regarding these provisions.

The law is fairly explicit on the makeup of the advisory council. Please review your council membership to determine if the minority and poverty groups within your area are represented. If they are, all you need to do is demonstrate that fact, in an appropriate manner, in the description of your advisory council. If these groups are not currently represented, then [illegible] will have to provide for [illegible] to the extent feasible [illegible].

With regard to the standards, you will note that the law states that they are to be established in accordance with criteria to be set by the Secretary. He has not as yet set the criteria so you cannot respond accordingly. You must, however, deal with this issue in your Ft 75 State plan.

If standards are already established or are being developed, you must describe your agency's involvement in setting the standards and state the types of facilities and programs to which the standards do or will apply. You may wish to include the standards or proposed standards in an appendix to your plan. There must also be an assurance that your standards will be reviewed in relation to the Secretary's criteria when they are set and that they will be amended or revised as necessary.

If licensure of facilities and programs is required in your State, or is about to be initiated, you must briefly describe the procedure, including the provisions for enforcement and penalties, the agency (or agencies) responsible for licensure, and the types of programs and facilities which must be licensed. There has been some confusion around the terms licensure, accreditation, and certification. For example, some States license facilities and certify or accredit programs. It does not matter what term or terms you use in your State but it is vital that the terms are clearly defined.

In the event that there are no established or proposed standards in your State and/or facilities and programs are not licensed, a statement to that effect must appear in your State plan and you must describe how and when you will meet these requirements. Since the process by which standards are set and licensure implemented in most States is a lengthy one, you should begin work in this area immediately.

In my l tter to you dated September 27, 1974, I suggested you use the existing NIMH Draft Guidelines to update your State plan for FY 75 funds and rewrite Sections V, VI, VII and VIII. The requirements for the standards will be addressed, then, in Section VI. To discuss the provision for the advisory council, all you need to do is detail which members of your advisory council represent poverty and minority groups.

I am leaving the Regional Office at the end of this month to accept a position within the State Assistance Branch, NIMH, Rockville. The Regional Mental Health Consultants will be able to answer questions you may have, and, you [illegible] Claude Sauter for clarification (phone [illegible]-2570).

Sincerely,

[illegible] 11/21/74

[illegible]

FEB 9 BR
See file

Procedure for Review of Alcoholism State Plans

State plans for prevention, treatment, and rehabilitation programs to deal with alcohol abuse and alcoholism must meet the requirements of the law and, in the absence of regulations, the requirements stated in the draft guidelines which are based on the current draft regulations.

State plans will be reviewed by Regional Office and central office staff. The procedure is as follows:

Regional Office

1. Notify each State alcoholism agency in your region of the number of copies of the State plan to be submitted to your office for review and advise them to send two (2) copies to the National Institute on Alcohol Abuse and Alcoholism, Attention: Mr. William C. Reeder, Acting Chief, State Assistance Branch, Room 16C06, 5600 Fishers Lane, Rockville, Maryland 20852. (The attached list of State alcoholism agencies is the most current list available in the central office. The completely updated list will be forwarded as soon as all State agencies have been designated.)

2. Review State plans by the method most appropriate and feasible for your office.

3. Request any addendum material necessary to render a State plan complete and approvable and send, or have sent, copies to Mr. William C. Reeder.

4. Submit a report and recommendation for each State plan to the State Assistance Branch, NIAAA. The report should include statements as to compliance or non-compliance with the law and the requirements contained in the guidelines; comments regarding any significant features; statements of any omissions and/or deficiencies; and other relevant comments. Recommendations may be a) approval (with or without conditions, b) disapproval, or c) return for further development.

5. Offer consultation as soon as possible to those States whose plans are either returned for further development or disapproved. (Staff of the State Assistance Branch will assist in every way possible.)

State Assistance Branch

1. Review each State plan

2. Contact Regional Office regarding omissions, deficiencies, or other issues pertaining to any State plan.

3. Assist Regional Office in securing necessary addendum material.

4. Assist Regional Office, as requested, in consultation with State agencies and/or in the review of State plans.

5. Submit Regional Office reports and recommendations, together with any comments Branch staff may have, to the Director, NIAAA. Final approval rest with the Director.

6. Take necessary action to implement the award of formula grant funds to States whose plans are approved.

In order to implement this vital program, it is essential that all State plans be approved and the awards made by June 30, 1972. Therefore, joint Regional Office--central office assistance must be provided to those States whose plans do not meet the basic requirements for approval as submitted.

STATE PLAN CHECKLIST MONTANA STATE PLAN FY 76

Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Programs
Title III, Part A, P.L. 91-616

STATE_____ F. Y. ____

DATES: Received_____, Reviewed_____

REVIEWER(S)_____

	*Covered Yes	No	Comments
I. Administrative Organization			
A. Single State agency	___	__	
1. Name & address	___	___	
2. Director: name & title	___	___	
3. Organization charts	___	___	
4. Functions	___	___	
5. Evidence of authority	___	___	
B. Supervised agencies			
1. Name & address	___	___	
2. Director	___	___	
3. Organization chart	___	___	

*This column merely alerts the reviewer to the items that must be covered in the State plan. The "Comment" column may be used to indicate acceptable, not acceptable, and any other comments.

DRAFT
2-4-72

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The following information regarding the advisory council must be included in the State plan:

1. name of the advisory council
2. membership roster (this should include each member's tenure dates, place of residence, position and/or pertinent interests, and organizational affiliations).
3. method of selecting members and chairman
4. number of members authorized
5. specific functions and authority of the council. (Include documents, if any, which establish functions and authority, such as bylaws and letters of incorporation).

IV. State Survey

The development of a comprehensive, coordinated State-wide alcoholism program plan requires a thorough ongoing study of the State to determine the social, economic, and medical needs for prevention, treatment, and rehabilitation programs to deal with alcohol abuse and alcoholism. This study must include a survey of existing resources, including existing services and facilities; State legislation affecting alcohol abusers and alcoholic persons; geographical, socioeconomic, and cultural makeup of the State; and the need for programs, services and facilities.

A. Pertinent State Information

The plan should contain any pertinent information about the State which will affect total programming and/or individual projects. For example: has the State implemented the Uniform Alcoholism and Intoxication Treatment Act or a similar Act; how do present State laws affect or provide for prevention, treatment, and rehabilitation of alcohol abusers and alcoholic persons; what is the State budget for such programs; and does the geography of the State enhance or impede coordination, continuity, and service delivery?

B. Descriptive Statistics

Descriptive statistics must be provided as available and taken from the most recent, reliable sources, such as the U.S. Bureau of Census, State Health Department vital statistics, State and local welfare statistics, State and local school district statistics, police and court statistics, etc. This must include at least the following basic

information: population figures by age, sex, and race (wherever possible, population projections should also be included); socioeconomic data, such as per capita income, unemployment rate, substandard housing, marital status, educational level, and caseload of categorical assistance programs; data on alcoholism and alcohol abuse and social problems related or contributing to alcoholism and alcohol abuse such as number of known alcoholic persons, number of alcoholic persons under treatment, number of arrests related to alcoholism or alcohol abuse, school dropouts, physically handicapped persons, mentally ill persons, offenders within the correctional system, etc.

These statistics are essential to the development of a State alcoholism program which meets the needs of those served and which contributes to the total growth and development of a State. Statistical tables should be included in the plan for background and reference. However, it is far more essential that the statistics be related in the narrative to the action plan. By so doing, the planned activities will be more appropriate and responsive to the needs of various age groups; socioeconomic groups; cultural and racial groups; the employed, unemployed and underemployed; various occupational groups; persons of varying educational backgrounds; and the known types of alcohol abusers and alcoholic persons, such as the employed alcoholic person, the "skid row" alcoholic person, the drinking housewife, the public inebriate, the drinking driver, etc.

C. Other Significant Information

Each State has other significant factors, such as Indian reservations, military bases, waterfront areas, "skid row" areas, universities and colleges, major industries, natural barriers, model cities, Appalachian areas, Alcohol Safety Action Project areas, etc., which must be considered in the development and implementation of the State plan. Each such factor must be analyzed as to potential resources, the actual or potential risk of alcoholism problems, the program necessary and appropriate for each, and the methods necessary for negotiation and joint planning.

In industry, for example, there are potential resources as well as problems of alcohol abuse and alcoholism. Industry can be a referral source leading to earlier case finding, it can provide an atmosphere conducive to prevention and rehabilitation, it can provide employment

for recovering alcoholic persons, and can provide financial support for prevention, treatment, and rehabilitation programs. Providing for the employed alcoholic and for preventive programs in industry contributes greatly to primary prevention, early intervention, and will result in great savings for the individual, the family, the community, and the State. Developing an appropriate program depends, of course, upon negotiation and planning with the industry and all other relevant agencies and organizations. The plan must include a description of each such significant factor and each must be related to the action plan in the narrative.

D. Existing Resources

A survey of existing resources must be undertaken. Such survey must include existing services, including type and volume of services rendered, facilities, personnel, and financial resources which are related to alcohol abuse and alcoholism prevention, treatment, and rehabilitation programs.

The plan must include a description of the resources and the methods by which they will be made an integral, coordinated part of the overall State program. It is also helpful to include a map indicating the location and type of existing services identified in the narrative. Program planners will then have a graphic picture to assist them in locating gaps in service, natural barriers to obtaining services, and various types of services which should be coordinated into comprehensive community service programs.

E. Survey of Need

The State must be surveyed to determine the need for prevention, treatment, and rehabilitation programs to deal with alcohol abuse and alcoholism, including a survey of the facilities needed. The survey must encompass the social, economic, and medical aspects of the problem of alcohol abuse and alcoholism. The State plan must incorporate by reference the following information regarding the survey of need:

1. The extent of the problem of alcohol abuse as well as the problem of alcoholism, including estimates and the basis for these estimates of the abuse problem and the number of alcoholic persons, their families, and/or significant others;

2. The relative demographic context for the problems of alcohol abuse and alcoholism considering both the proportion of the population with such problems and the total number of people directly or indirectly affected. Taken into account must be the demographic and socioeconomic factors related to alcohol abuse and alcoholism, such as low per capita income, chronic unemployment, substandard housing, and other health and social problems; and

3. The special needs of specific groups, such as drirking driver, employees (State and local government and private) with problems of alcohol abuse and alcoholism, the chronic public intoxicant, migrant workers, occupational groups at risk, offenders within the correctional system, and groups whose age, social, racial, and/or cultural category make them more vulnerable to alcohol abuse and alcoholism.

V. State Alcohol Abuse and Alcoholism Comprehensive Action Plan

The State plan must include the State's proposal for the development of more effective prevention, treatment, and rehabilitation programs to deal with alcohol abuse and alcoholism. The proposal, or action plan, must:

A. Be based upon the survey of need,

B. Utilize to the maximum extent possible existing resources, services, and facilities, and

C. Provide for the development, through the utilization of governmental and nongovernmental resources, alcohol abuse and alcoholism programs which will meet local needs throughout the State, particularly the special needs of the specific groups, as identified in the survey.

The action plan must include the activities to be carried out under the plan. The activities must be ranked according to priority and the criteria for establishing priorities must be described. The activities planned by each State will vary according to that State's resources and needs as will the ordering of priorities.

VI. Standards and Evaluation

It is desirable that States develop standards for the operation of alcoholism and alcohol abuse prevention, treatment, and rehabilitation programs and facilities and that they develop mechanisms for evaluation at least annually for compliance with established standards. If a State does so, the State plan must include a description of these standards and the mechanisms for evaluation.

Carefully developed standards will result in more effective, high quality programs and will allow for ease of monitoring. Standards must, of course, be realistic and attainable, but should also be specific and clear.

VII. Participation by Other Public or Private Nonprofit Agencies

Formula grant funds may be made available by the State agency to other public and private nonprofit agencies, institutions and organizations which administer activities which qualify for inclusion in and support under the State plan. In determining to which agencies, institutions, and organizations funds are to be made available, and the amount of which is to be available to each, the State agency must consider the extent to which the services to be provided will be directed to alcohol abuse prevention, treatment, and rehabilitation programs of high priority, will be of high quality, and will reach the people in local communities in greatest need of such services. The State plan must incorporate by reference the policies and procedures by which the determination and distribution of funds will be made. The plan must also incorporate by reference the mechanisms established to inform eligible agencies, institutions, and organizations of the availability of Federal and State funds for the conduct of activities, including those locally initiated or sponsored, under the State plan.

VIII. Coordination of Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Programs

The State agency must be responsible for the review of all project grant applications submitted pursuant to Section 2?? of the Community Mental Health Centers Act. It is also desirable that this agency be authorized to review other applications submitted under Part C of the Community Mental Health Centers Act. When requested, the State agency must also review alcohol abuse and alcoholism program grants submitted

related to planning, establishing, maintaining, coordinating, and evaluating projects for more effective prevention, treatment, and rehabilitation programs to deal with alcohol abuse and alcoholism.

In determining how the formula grant funds will be utilized in carrying out the activities stated in the plan, the State agency should consider all other sources of funds available; Federal, State and local governmental, and private funds, including third party payments and charitable contributions. By using these other funds in the most efficient, appropriate way, more can be done with the formula grant funds which are availble to implement the plan.

The initial State plan and each annual updated plan must contain a projection of the estimated amount of the formula grant funds allotted in the fiscal year for which the plan is written which will be utilized for specific planned activities. Each activity should be sufficiently detailed to allow for estimating its cost so that the State agency will be able to determine the extent to which the State plan may be implemented in any fiscal year.

The proposed action plan for each fiscal year should include all activities deemed necessary at that point in time to develop a total, State-wide, comprehensive alcoholism program. The activities should be based upon stated goals and objectives and these goals and objectives should be ranked in priority order according to the needs of the State. Once the objectives and the activities necessary to meet the objectives are identified, a projected cost based upon the best estimate should be assigned to each activity and the anticipated source or sources of funds should be identified. Finally, since it is unlikely that States will be able to implement all planned activities in any one fiscal year, a projected timetable for implementation should be established.

Developing the action plan in this way will prove beneficial in many ways. For example, it will provide information vital to the budgetary process at the State, local, and Federal levels, and will allow for flexibility in the use of formula grant funds in a planned relevant manner. Planning for a total comprehensive State-wide program, rather than on the basis of the amount of funds available in any one year, will facilitate the determination of the steps necessary to develop community based services, direct and indirect, for all the people of the State in the most effective and efficient manner.

State of Montana

Department of Institutions

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THOMAS L. JUDGE

ROBERT H. MATTSON

BOARD MEMBERS
ZELLA A. JACOBSON, CHESTER
ELDON E. KUHNS, BILLINGS
WILLIS M. McKEON, MALTA
ROBERT J. PALLO, KALISPELL
JOHN W. STRIZICH, M.D., HELENA

MONTANA STATE PLAN FY 76
Helena, 59601

February 21, 1976

Ms. Naomi Kennedy
Rm. 11037, Federal Office Bldg.
1961 Stout St.
Denver, Colorado 80202

Dear Naomi:

Pursuant to our conversation of February 20, 1976, I am enclosing the following material as addendum A, to our January 30, 1976, letter altering the State of Montana Alcohol Plan and meeting special conditions as outlined in Dr. Hilary Connor's letter to the State of Montana.

1. The Montana Alcohol & Drug Dependency Advisory Council, at their January 28, 1976, meeting at Fairmont Hot Springs, Opportunity, Montana, voted unanimously to approve spending the Federal alcohol formula funds on a regional basis -- employing a coordinator and developer of alcohol services who will also serve alcoholics on an information and referral basis and implementing Montana's Uniform Detoxification Act. Advisory Council members present: VanHorne, Herlevi, Basbender, Hanrahan, Hall and Skelton. Absent members: Pettit and Kipp. Advisory Council members have received a copy of the January 30, 1976, letter to you and will receive a copy of Addendum A.

2. Each of Montana's five Mental Health Regional Boards will receive $40,000 of federal alcohol formula funds to be utilized in the following manner:

A) $25,000 to hire and pay all ancillary expenses of a coordinator and developer of alcohol services who will also serve all alcoholics in his region on an information and referral basis of alcoholics to services available in Montana. This regional staff members will provide direct services to alcoholics needing services by referring them to services now available in Montana. In addition to providing direct services to alcoholics this regional staff member will develop new services where needed in each region and coordinate services currently available to avoid duplication and waste of available alcohol dollars

MONTANA STATE PLAN FY 76

4. With the Montana Addictive Diseases Bureau - Management Information System will meet the data requirements of each local program and State program. In addition to information received through the MIS, staff members of the Addictive Diseases Bureau will conduct on-site reviews of each regional office and all alcohol programs twice each fiscal year. The reviews will consist of: budget, client files, documentation of services provided and existence of clients served. As stated in our January 30, 1976, letter currently an alcohol MIS is not funded and staff members for the two positions not hired. Exhibits A - E attest to the vacancy of these positions as mailed to you January 30, 1976.

5. Following is an organizational chart of the Department of Institutions and biographical data on key staff members in the Addictive Diseases Bureau. Exhibits F through N.

I am very confident that the State of Montana has now responded to all questions concerning our Plan expenditure of FY '75 formula funds and we can start expending these funds in early March, 1976.

Sincerely yours,

Robert H. Mattson, Ed.D.
Director

b) $15,000 of federal alcohol formula funding to be used as follows:

1) $5,000 to be utilized for education and training needed to implement the Uniform Detoxification Act.

2) $10,000 to be utilized for care provided by medical facilities implementing the Uniform Detoxification Act. Payment for services received by alcoholics will be made only after documentation and verification of the service is made by the regional coordinator assigned to each of the five regions.

The goal of the Montana Addictive Diseases Bureau utilizing federal alcohol formula funding is to develop comprehensive alcohol services in each region to serve alcoholics, their families and provide prevention-education about alcohol to residents of each region. The objectives necessary to meet the goal are as follows:

A. To hire one regional staff member to coordinate, develop and serve as an information and referral resource to all residents of the region.

B. To facilitate residents of the region into treatment programs as necessary.

C. To identify all services now available for alcoholics in each region.

D. To identify services now needed and not available in each region.

E. To hold public meetings to obtain citizen input on whether to develop or contract with other regions for services needed but not available in each region.

F. To develop those services not available but desired in the region by alcoholics and residents at risk.

G. To provide for accurate and documentable expenditure of funds for medical detoxification of alcoholics.

H. To train agencies in the region that they may comply with and implement Montana's Uniform Detoxification Act.

I. To have the regional coordinator responsible for patient care when provided by a hospital in each region.

When each of the objectives (A through I) are met, the goal will also then be met.

3. Montana currently has the following services available to alcoholics.

GREAT FALLS - The City County Health Department operates a comprehensive range of services. This includes intermediate care, inpatient treatment, outpatient, follow up, education

and prevention. Detox is available on a limited basis. These services are provided on a contractual arrangement. This community program received $148,529 in funding from the State Alcohol Authority. They also have additional funding from City and County revenue sharing, Voc. Rehab. fees for service. They serve primarily the residents of Cascade County.

BILLINGS - The Rimrock Guidance Foundation is the agency providing alcohol services. This agency provides detox services through a contract with the Deaconess Hospital. Rimrock provides intermediate care for both male and femald, outpatient follow up, education, prevention and referral. In patient treatment capability is being developed and will be operational soon. This program received $42,646 from the SAA for the current fiscal year. They also receive a significant amount of funding from the United Givers and from client fees.

CUSTER COUNTY - The County Health Department operates a referral and outpatient counseling service. This county program has received $9,500 from the SAA and has additional funds from County revenue sharing. The service area is Custer County.

COUNCIL OF COUNTIES - District I - This group of 5 counties provide referral and outpatient counseling services. They are operating on $40,829 from the SAA and revenue sharing funds from the participating counties. The service area is the 5 counties in the northeast corner of the State.

COUNCIL OF COUNTIES - District II - This is a group of four counties in the eastern central portion of the State. They provide referral and outpatient counseling. Their funding from the SAA is $28,200 with additional funds from county revenue sharing from the four counties.

ROSEBUD COUNTY - The County Health Department operates a referral and outpatient counseling service. They are receiving $4,636 from the SAA and also utilize county revenue sharing. The service area is the county.

NORTHWEST MONTANA ALCOHOL PROGRAM - Kalispell - This program serves Flathead and Lincoln counties, provides referral, outpatient counseling, education and prevention. They have been funded with $42,411 from the SAA and also have county revenue sharing, united givers, fees for service, Voc Rehab and CETA.

HILLTOP RECOVERY CENTER - Havre - This program provides detox, inpatient treatment, intermediate, outpatient, referral, education and prevention for seven counties in the North central portion of the State. They have received $54,700 from the SAA and receive revenue sharing funds from each of the seven counties served. In addition, they have some United Givers and City revenue sharing funds and fees for service.

ALCOHOL REHABILITATION ASSOCIATION - Helena - This program provides detox, outpatient counseling, referral, education and prevention in ten S. W. Montana counties. They are funded with a Federal Staffing grant, County revenue sharing, United Givers, Voc. Rehab. and $60,609 from the SAA.

COLSTRIP YOUTH PROJECT - This program located in the high impact coal area of southeastern Montana provides referral and outpatient counseling to high school age youth. It is funded with county revenue sharing funds, NIDA funds through the SDA, Voc Rehab and $9,750 from the SAA. Service area is primarily the town of Colstrip.

FRONTIER ALCOHOLISM PROGRAM - Dillon - This program provides detox, referral and outpatient counseling for the residents of Beaverhead County. It is funded with County and City revenue sharing funds and $30,000 from the SAA.

DEER LODGE COUNTY - This county program provides referral and outpatient counseling for the residents of Anaconda and the county. It is funded with county revenue sharing money and $15,795 from the SAA.

GALEN ALCOHOL TREATMENT CENTER - This program is State operated and provides detox and inpatient treatment for residents of the State

BOYD ANDREWS' GUEST HOUSE - Helena - This is a twelve step house providing residence for five clients. They provide referral and counseling.

BLACKFEET ALCOHOLISM PROGRAM - This program serves the reservation indians at Browning. A comprehensive range of service is offered, including detox, outpatient, counseling, prevention, rehabilitation, information and referral. The sources of funding are IHS - $47,000 and NIAAA - $40,000. Total level of funding - $87,700.

NORTHERN CHEYENNE ALCOHOLISM PROGRAM - This program serves the reservation indians of Lame Deer. A comprehensive range of service is offered which includes: detox, intermediate care, counseling, outreach, information and referral. The sources of funding are: IHS - $37,800 and NIAAA - $54,000. The total level of funding is $91,800.

FLATHEAD ALCOHOLISM & DRUG ABUSE PROGRAM - This program serves the reservation indians at Ronan. They also operate an information and referral service in Sanders County. A comprehensive range of service is offered, which includes detox, intermediate care, counseling, outreach, follow up, prevention, education information and referral.

The tribe recently donated a new building to house the program's detox and intermediate care components. Sources of funding include: IHS - $50,728, NIAAA - $29,000 and NIAAA $135,000. The total level of funding is $214,728.

FORT BELKNAP ALCOHOLISM PROGRAM - This program serves the reservation indians at Harlem. A comprehensive range of service is offered which includes detoxification at the Indian Health Hospital, intermediate care, counseling, information and referral. The sources of funding are: IHS - $45,280 and NIAAA $42,964. The total level of funding is $88,244.

ROCKY BOY ALCOHOLISM PROGRAM - This program serves the reservation indians at Box Elder. A comprehensive range of service is offered, which includes detoxification, intermediate care. counseling, information and referral. The sources of funding are: IHS - $33,600 and NIAAA - $30,000. The total level of funding is $63,600.

FORT PECK RESERVATION ALCOHOLISM PROGRAM - This program serves the reservation indians at Poplar. A comprehensive range of service is offered, which includes detoxification, intermediate care, counseling, outreach, prevention, thrift shop, information and referral. Sources of funding include: IHS - $68,200, NIAAA -$33,200 and suplemental NIAAA $24,000. The total level of funding is $125,400.

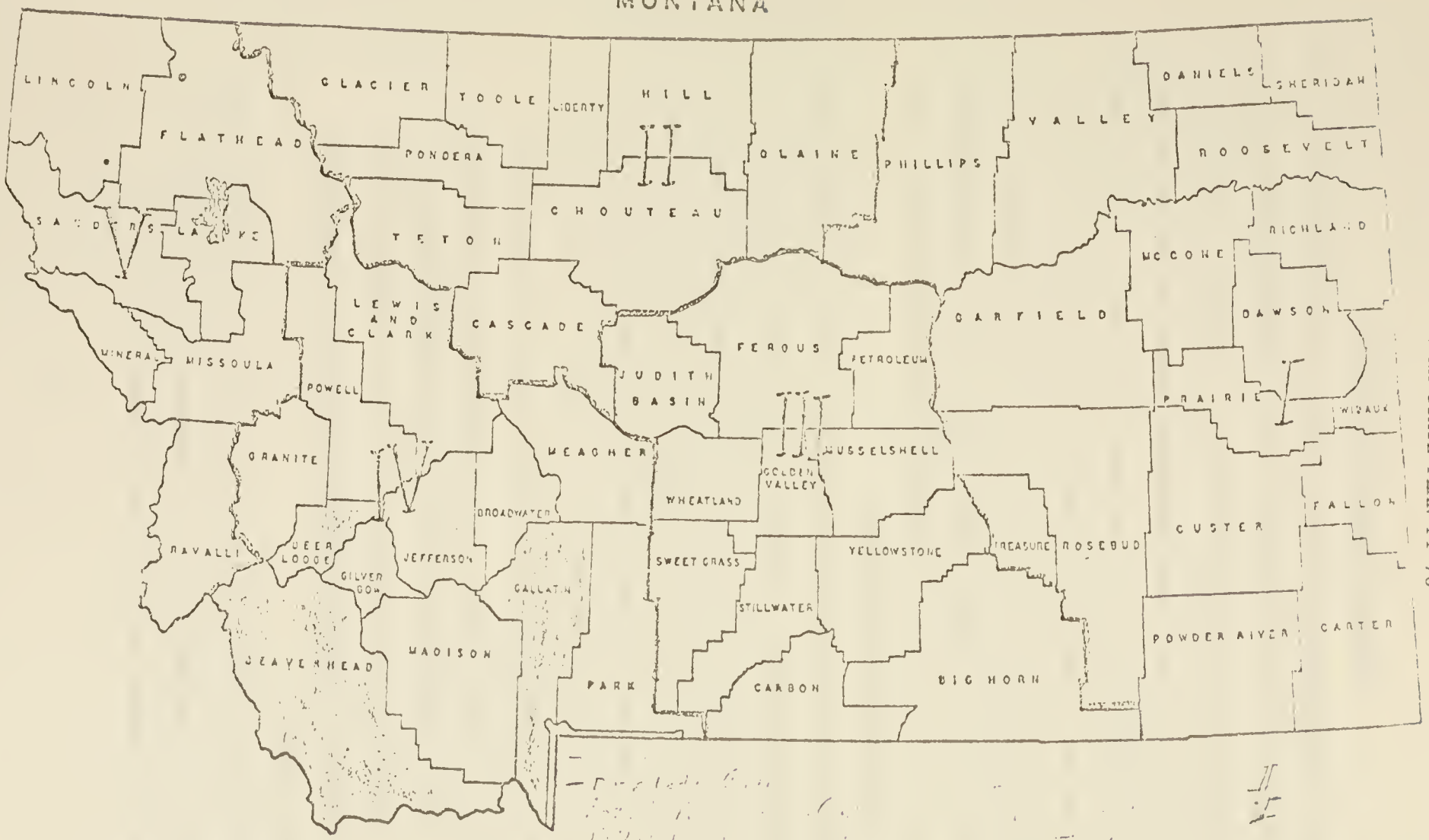
CROW RESERVATION ALCOHOLISM PROGRAM - This program serves the reservation indians at Crow Agency. A comprehensive range of service is offered, which includes: detoxification, counseling, information and referral. The sources of funding are: IHS - $47,400 and NIAAA - $30,000. The total level of funding is $77,400.

NORTH AMERICAN INDIAN ALLIANCE - This program serves the urban indians within the City of Butte. Services offered include information and referral, education and counseling (individual and family). The source of funding is NIAAA - $42,328.

MISSOULA INDIAN ALCOHOL & DRUG SERVICES - This program serves urban indians within the City of Missoula. Services offered include information, referral and counseling. The source of funding is NIAAA - $64,000.

Two urban indian alcohol programs have been approved for funding, but the monies have not been awarded. They are BILAMIWCO in Billings and the Indian Education Center in Great Falls.

The Montana Indian Commission on Alcohol and Drug Abuse had their federal funding discontinued.



No. 1050 — County Outline Map
STATE PUBLISHING COMPANY
Helena

MONTANA STATE PLAN FY 76

Montana, geographically the fourth largest state in the union, is also one of the nation's least populated states. Montana has less than a dozen communities with a population density of 20,000 or more people. Montana borders three rural Canadian provinces on the North, the Dakotas to the East, Wyoming to the South and Idaho to the West.

In recent years, workers in the social service fields have observed an alarming increase in both use and abuse of alcohol in Montana. This has created an ever increasing need for alcohol service programs within the State and also the need for a standard management information system to monitor and evaluate these services.

In Montana, the State Alcohol Authority and the State Drug Authority share the same State Advisory Council. Alcohol Services Division was transferred by legislative action from the State Department of Health and Environmental Sciences to the Department of Institutions as of July 1, 1975. The same act also transferred the Addictive Diseases Unit and the Office of the Drug Coordinator from the Governor's Office, to unite alcohol and drug authorization in a single administrative unit called the Addictive Diseases Division. This reorganization was undertaken to correct a growing fragmentation of State level responsibilities for alcohol planning and service delivery as well as to respond to local regional requests for closer coordination and control of alcohol and drug program efforts.

The Addictive Diseases Division is now ready to fully commit itself to development and implementation of a Management Information System for alcohol service programs, which will meet Federal, State and local

needs. At the present time, the Addictive Diseases Division is not funded or staffed to develop such a system. With funds and assistance requested by this proposal, the needs assessment and system design would be completed, assuring a State commitment for continuing development and implementation.

STATE OF MONTANA
DEPARTMENT OF ADMINISTRATION
PERSONNEL DIVISION

CLASS SPECIFICATIONS

CLASS CODE: 127011
GRADE: 15
LAST UPDATED: 7-1-74

OCCUPATIONAL GROUP: Managers and Officials D

MONTANA CLASSIFICATION TITLE: Program Manager III

DESCRIPTION OF WORK

GENERAL DUTIES: Performs supervisory and professional duties in planning, coordinating and directing a specific program or service program for a particular clientele.
SUPERVISION RECEIVED: Works under general guidance and direction of an administrative superior.
SUPERVISION EXERCISED: Exercises supervision over clerical and other personnel

EXAMPLE OF DUTIES

Assesses needs and problems of a particular clientele and develops policies, Consults with administrative, supervisory, and operating personnel to determine and define problem areas; analyzes such problem areas as organization, personnel and equipment utilization, forms design and function, systems, procedures, etc., to determine needed modifications or improvements; devises and recommends solutions to such management problems as procedures design using such techniques as flow charts, time motion studies, and energy consumption analyses to eliminate duplication, facilitate work flow, and assure optimum utilization of equipment and staff; studies existing performance standards, recommends changes where needed, and establishes system of reporting to assure conformance with accepted standards and practices; conducts special investigations, surveys, and analyses as assigned; prepares reports and findings; performs related work as required.

MINIMUM QUALIFICATIONS

KNOWLEDGES: Working knowledge of the principles and techniques of management and organizational analyses, principles of administration; office engineering, forms design, business machine utilization; systems and procedures analyses; industrial psychology, sociology and engineering; accounting, research methods; statistics.
SKILLS: None.
ABILITIES: Ability to conceive, plan and conduct management analysis studies and surveys; to analyze and interpret complex data, write reports clearly and effectively; to develop methods and techniques for solving varied, complex management problems; to work effectively with others; to think creatively, integrate concepts; to present ideas effectively.
EDUCATION: Graduation from a college or university with a Bachelor's degree involving major study in Public Administration, Business Administration, Personnel Management or a closely related field.
EXPERIENCE: One year of administrative supervisory or consultative experience.

OR

Any equivalent combination of education and experience.

6201 3501 5103 6901

DEPARTMENT OF ADMINISTRATION
PERSONNEL DIVISION

SPECIFICATIONS

GRADE > 3>>

LAST UPDATED > 7-1-7

OCCUPATIONAL GROUP: Secretaries E

MONTANA CLASSIFICATION TITLE > Secretary I

DESCRIPTION OF WORK

GENERAL DUTIES: Performs routine typing and secretarial work for a limited number of people.
SUPERVISION RECEIVED: Works under close supervision of an administrative superior.
SUPERVISION EXERCISED: None.

EXAMPLE OF DUTIES

Types reports and various correspondence; acts as a receptionist; arranges appointments, interviews and travel schedules for supervisor(s); composes routine correspondence; takes dictation when needed; may keep and prepare payroll and accounting records; performs related work as required.

MINIMUM QUALIFICATIONS

KNOWLEDGES: Some knowledge of standard business procedure, grammar, punctuation and spelling.
SKILLS: Skill in the use of a typewriter and in taking shorthand.
ABILITIES: Ability to meet and deal effectively with a wide range of individuals; to compose effective routine correspondence and memoranda; to instruct and supervise the performance of others when applicable; to learn clerical tasks readily; to make routine decisions independently.
EDUCATION: One year of secretarial coursework at a college or technical school.
EXPERIENCE: One year of experience in general office work.

OR

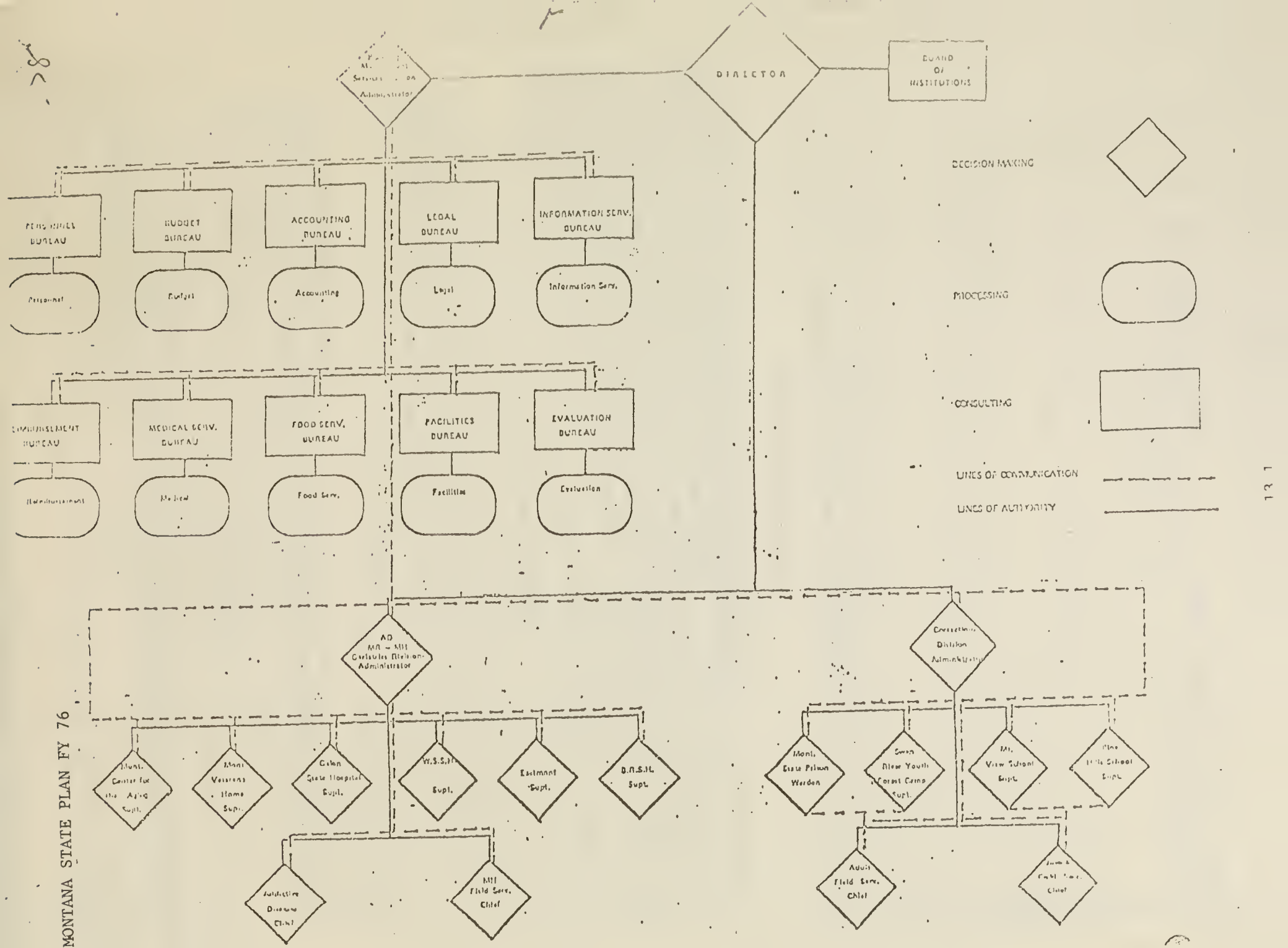
Any equivalent combination of education and experience.

USE BY AGENCIES

	All	*	As Noted Below		All Except Those Noted Below

3501 4102 5103 5105 5106 5115 5120 5401 5801 6401 6402 6407 6403
6412 6413 6505 6602 6702 6827

NOTE: Duties described above are not necessarily all inclusive for this class.



MONTANA STATE PLAN FY 76

Name: Robert H. Mattson, Ed. D.

Social Security: 517-24-9797

Address: 1905 Virginia Dale Avenue
Helena, Montana 59601

Marital Status: Married; four children

Education:

Montana State University	B.A.	(1949)
State University of Iowa	M.A.	(1950)
University of Oregon	Ed.D.	(1959)

Experience:

1943-46	U.S. Navy		Hospital Corps
1950-51	Kalispell Schools	Kalispell, MT	Special Education
1951-52	Eastern Texas State	Commerce, TX	Speech Correction Teacher & Clinical Work
1952-55	Eastern Montana College	Billings, MT	Dir. Special Education
1952-55	Mont. Handicap. Child. Ctr.	Billings, MT	Coordinator
1955-57	Mont. Handicap. Child. Ctr.	Billings, MT	Coordinator
1957-59	University of Oregon	Eugene, OR	Instructor, Educ. Counselor
1959-63	University of Oregon	Eugene, OR	Coord., Educ. of Excep. Child.
1965-75	University of Oregon	Eugene, OR	Asst. to Pres., Univ. in MR Pro.
1963-68	University of Oregon	Eugene, OR	Chrmn., Dept. of Spec. Ed.
1968-71	Univ. of O. Medical School	Portland, OR	Professor
1970-75	University of Oregon	Eugene, OR	Associate Dean, Research & Development
1975	Montana State Department of Institutions	Helena, MT	Director

Distinctions:

Recent Publications

Hill M. Walker, Interim Report: Identification and Treatment of Social-Emotional Problems, Eugene, Oregon, University of Oregon Press, 1967.

Robert L. Mattos and Hill M. Walker, "The Development of Educational Procedures for Modifying Deviant Behavior in Children," submitted to The Journal of Special Education, December, 1967.

Robert L. Mattos, Hill M. Walker, and Nancy K. Buckley, Reinforcement and Aversive Control in the Modification of Behavior; Academic Therapy Quarterly, 5, Fall, 1969, pp. 1-16.

Organizations: APA (American Psychiatric Association)
CEC (Council for Exceptional Children)

PROFESSIONAL RESUME

OF

Michael Anthony Murray
607 West Lawrence
Helena, Montana 59601

406-443-3197

I. Personal Characteristics:

Born September 29, 1941, to Roger and Opal Murray.
Father died 1955.
Mother currently employed by State of Montana.
Honorable Discharge, U.S. Army Reserve, 1966.

II. Family Status:

Married Helen Cronin August 1964;
Son - Michael (Age 10)
Daughters - Maura (Age 4), Jennifer (Age 1)

III. Education:

a. St. Helena Grade School, Helena, Montana - 1946-1955

b. Cathedral High School, Helena, Montana - 1955-1959

c. Carroll College, Helena, Montana - 1960-1964
Graduated with Bachelor of Arts
Dual major in English and History
Dual minor in Philosophy and Education

d. Nevada Southern University, Las Vegas, Nevada - 1964-1965
9 hours Guidance and Counseling

e. University of Montana, Missoula, Montana - 1967-1970
17 Hours graduate credit with a Psychology emphasis

IV. Experience:

a. 1956-1960 - Part-time work: Laundry and dry cleaning plant, restaurant as bus boy and waiter.

b. 1960-1964 - Summers - U.S. Forest Service - Engineering Survey crew boss, Helena, Montana.

c. 1961-1964 - Winters - Capri Lounge, Helena, Montana - Bartender.

d. 1964-1965 - Gorman High School, Las Vegas, Nevada - Teacher-Coach.

e. 1965-1967 - Montana State Prison, Deer Lodge, Montana - Teacher-Curriculum Director and Assistant Director of Education. At the prison, I established the curriculum for adult basic education and started a program of college extension for inmates through the University of Montana at Missoula.

f. 1967-1972 - Rocky Mountain Development Council Inc.; Helena, Montana.

Executive Director of the agency at an annual salary of $14,400. I had a staff of 128 people working with me. The Rocky Mountain Development Council is a Community Action Agency funded for 1.4 million dollars serving Broadwater, Jefferson and Lewis and Clark Counties.

I started my employment with the RMDC as Director of Head Start and was promoted to Deputy Director of the Agency in July, 1968. I was promoted to acting Executive Director in August, 1969 and received full authority of the position in October, 1969.

In my position with the RMDC I was responsible for the overall operation of the agency. During my three years as Executive Director the funding for the agency more than doubled.

g. 1972-1973 - Southwestern Areawide Comprehensive Health Planning Council, Inc.; Helena, Montana.

Employed as the Health Planner for a four county area: Lewis and Clark, Jefferson, Broadwater and Meagher at an annual salary of $15,100. My duties in this position consisted of formulation of a Comprehensive Health Plan and implementation of the plan. In my position, I completed a manual of all Health and Social Services resources for the Helena area, worked with the White Sulpher Springs community on development of a new nursing home, assisted Jefferson County on a rural nurse project, and have written several grants for city and counties pertaining to health. Organized the group that established and operates the Social Club for Retarded Adults of the Helena area.

h. 1973-1975 - Southwestern Montana Drug Program, Deaprtment of Institutions, Helena, Montana.

Administrative Director of this drug treatment and rehabilitation program at a salary of $19,000 per year. Duties include: Plan, organize, assign and evaluate the work of the program's 32 staff members in the treatment and rehabilitation of clients (310 static matrix) within the drug program; supervise contractual agreements with affiliates of the drug program. Directs and coordinates all staff services such as office management, purchasing, accounting, records management budgeting, personnel administration and community relations. Currently the program

serves Montana Mental Health Region IV. Program is developing plans to expand to Mental Health Regions II and III. With program staff developed program into the nation's "rural model" as described and utilized by the National Institute of Drug Abuse - HEW.

f. 1975-Present - Addictive Disease Division, Department of Institutions, Helena, Montana.

Acting Director of the Division at an annual salary of $21,000. Responsible for coordinating all alcohol and drug services in the State of Montana as mandated by House Bill 699. Currently responsible for all plans, contracts, treatment and prevention programs in the state. Supervise a staff of 99 employees and budget of 2.3 million dollars.

V. Job Related Experience:

a. 1969 one of ten people west of the Mississippi selected to plan and put on the Western National Head Start Conference.

b. Summers 1968 and 1969 contracted with the Volt Technical Corporation as a subcontractor to train all summer Head Start staffs in Montana. Training provided for Billings, Butte, Anaconda, Kalispell and Helena staffs.

c. 1970 represented the State of Montana at the first National 4 C's conference in Washington, D.C., selected by the Regional Office of Child Development.

d. 1970 contracted with the Office of Economic Opportunity to sponsor a week training and orientation for VISTA volunteers serving Broadwater, Jefferson and Lewis and Clark Counties.

VI. Awards, Organizations:

a. Selected for membership in Who's Who in the West - 1975.

b. Selected as a member Outstanding Young Men of American - 1972.

c. Appointed member Governor's Ancillary Manpower Planning Council - 1971.

d. Appointed member of Montana First Governor's Conference on Libraries - 1971.

e. Member Helena Neighborhood Center Advisory Committee - 1971.

f. Elected member Board of Directors Helena Model Cities.

g. Member Last Chance Kiwanis Club.

h. Member Last Chance Kiwanis Club.

i. Past President; Secretary-Treasurer, Capital City Lions Club.

Paul A. Babbitt, Consultant
Alcohol Services Division
Montana Department of Health and Environmental Sciences
Helena, Montana 59601

Born:	May 31, 1926 Kalamazoo, Michigan
Education:	
1956	Michigan State University, East Lansing Michigan - Communication Arts - Bachelor of Arts
1970	Columbia University, New York City, Counseling Psychology and Education Master of Arts
	Additional 28 Graduate credits in Rehabilitation Counseling at the University of Wisconsin, Madison, Wisconsin
	Alcoholism Training at the National Alcoholism Training Program for Professionals sponsored by the Social Science Institute, Washington University, St. Louis, Missouri
Military Experience:	
May 1944 to December 1947	U.S. Navy Medical - Pharmacist's Mate Second Class
Civil Experience:	
April 1972 to present	Alcoholism Program Planning and Grants Management - Alcohol Services Division, Montana Department of Health and Environmental Sciences, Helena, Montana
	The previous 12 years were spent in various rehabilitation projects. Primary function was supervision and administration including two years of teaching special aspects of administration at Columbia University.

MONTANA STATE PLAN FY 76

RESUME

Robert W. Anderson
304 S. California
Helena, Montana 59601

Office (406) - 449-2827
Home (406) - 443-4787
SS# 516-48-8645

Personal Data

Marital Status: Married
Wife: Donna, 28
Daughter: Gina, Age 8
Son: Robert, Age 5

Height: 5'9"
Weight: 165
Date and Place of Birth: Helena, Montana -6/2/45
Health: Excellent
Disabilities: None

Education

Helena Senior High School, 1973 Graduate
University of Montana, Missoula, BA Degree, Sociology, 1967
Williams AFB, Arizona, USAF Pilot Training, Graduate 1969
Tyndall AFB, Florida, USAF Instructor Pilot Training, Graduate 1969

Licenses and Non-Academic Vitae

FAA Pilot License
Intrument Rating
Commercial Rating
1875 hrs. multi-engine Jet (T-38 and T-37)
60 hrs. Single Engine Propellar (Cesna 150-172)
Master Certificate of Instructor Flying USAF 6/71
USAF Commendation Medal for Meritous Service May 8, 1973
Personnel Management Course - DRTC, Civil Service Commission
State Classification Seminar - 11/73
Labor Relations Seminar - 12/73, 3/74
Supervisory Workshop - 5/74
Drug Abuse Single State Core Course - 11/74
National Institute on Drug Abuse Reporting Workships - 10/74, 12/74, 4/75, 8/75

Work Experience

September 1974 - present — Department of Institutions, Addictive Diseases Division, Program Manager

Responsible for the implementation, management and administration of a State-wide Integrated Drug Abuse Reporting Process. Determined and developed the number, type, frequency and distribution of reports to be generated for State level program management. Developed training plans for community based treatment personnel, field representatives, local coordinators, and selected office staff for implementation of the reporting system. Established and scheduled on-site training sessions. Managed data flow and resolved problems reagrding the data. Continually assessed and modified the overall reporting system. Established and maintained a quality control and checking procedure to verify data and pinpoint deficiencies. Assisted State drug programs in meeting reporting standards. Produced output reports for programs. Developed and maintained office and program records. Assisted in the development of a Drug Abuse Training System. Developed and edited a bi-monthly Drug Abuse Newsletter.

July 1973 - September 1974 — Department of Revenue, Personnel Officer

Responsible for all Personnel functions within the Department of Revenue. Interviewed all applicants for professional and nonprofessional employment. Collected and screened applicants for hiring officials and conferred with them on approval of employment. Responsible for recruitment, classification, wage and salary development. Advised operating supervisors and officials on rules, regulations, promotions, demotions, transfers and other personnel practices. Compiled and maintained employees' fringe benefit records such as group health insurance and sick and annual leave. Advised and informed employees on all Personnel matters. Developed employee manuals, newsletter, booklets, and other informational materials.

September 1971 - May 1973 — Laughlin AFB, Texas 3646 Maintenance USAF Functional Check Flight Pilot

Test flew and checked out T-37 and T-38 aircraft to determine air worthiness and operational safety following major maintenance and repair work. Also responsible for personnel records, flight scheduling within the Functional Check Flight Section.

August 1969 - September 1971 — Laughlin AFB Texas, 3646
Pilot Training Squadron
Instructor Pilot

Instructed student pilots in the advanced phase of the USAF pilot Training Program. Also performed duties as Flight Standardization Officer responsible for the maintenance and standardization of all student flying and personnel records within the flight. Counseled students having problems in flying skills or academic ability, and made recommendations to Flight Commander - counseled students in personal problems which could affect student's performance on flying safety and made recommendations for solutions. Served as Flight Scheduling Officer and scheduled all training flights within the flight.

1963 to 1960 — Montana Highway Department
Materials Division
Lab Technician

Conducted soil and concrete tests. Summer work while attending college.

1960-to-1978 — Anderson Clothing Company
Clerk

Sold men's clothes and helped with bookkeeping. Periodically did this work while attending high school and college.

References: Furnished upon request.

MONTANA STATE PLAN FY 76

BIOGRAPHICAL DATA - FRED W. BARTA
Anaconda, Montana 59711

7/27/73

Address: 613 W. Commercial

Married to Joan Barta - Have two children

EDUCATION:

1. Edgar Public High School - Edgar, Montana - 1960

2. Rocky Mountain College - Billings, Montana -
B.A. - Psychology - 1969

3. Eastern Montana College - Billings, Montana -
M.S. - Rehabilitation Counseling - 1971

EXPERIENCE:

1. Stanford Research Institute
San Mateo, California

Trainer-tester - temporary
3 weeks between October 1969 - November 1969
Salary $40/per actual working day.

2. Veterans Administration Neuropsychiatric Hospital
Sheridan, Whoming

Graduate Intern - Psychology Service
March 1971 - May 1971
No salary - SRA stipend

3. Washington Center for Addictions
41 Morton Street
Jamaica Plains, Massachusetts 02130

Post-Masters Professional Trainee
September 1, 1971 - June 30, 1972
No salary - National Institute of Mental Health Grant

4. State of Montana
Department of Institutions
Montana Drug Program - Phase I
225 South Idaho
Butte, Montana 59701

July 25, 1972 - Present
Present position - Director of Treatment and Rehabilitation

George L. Swartz
926 Sierra Rd. W.
Helena, Montana 59601

Born: 11/4/37 - Jordan, Montana

Marital Status: Married - 4 children

EDUCATION:

Jefferson County High School
Boulder, Montana
General - Diploma 1956

Carroll College
Helena, Montana
Pre-Med 1956-1957

Montana State University
Bozeman, Montana
Education - B.S. 1965

Montana State university
Bozeman, Montana
Counseling - M.Ed 1969

University of Montana
Education - 1972

Utah State - San Jose State -
Tech. of Instru. Dev. - 1972

American Management Association
Management - Certificate

EXPERIENCE:

- Various summer jobs.

1958 - 1962 - U.S. Navy

1965 - 1967 - Montana State University - Resident Supervisor - Resident Halls.

1967 - 1968 - Summers - Boulder River School and Hospital - Rehabilitation Counselor & Teacher

1967 - 1969 - Whitehall Public - Counselor and Assistant Principal

1969 - 1971 - Shelby Public Schools - Counselor

George L. Swartz
Resume
Page 2

1971 - Office of Supt. of Public Instruction - Drug Education Consultant

1971 - 1973 - Office of Supt. of Public Instruction - Drug Education Supervisor

1973 - 1974 - Addictive Diseases Unit - Office of the Governor - Assistant to Drug Coordinator

1974 - Present - Addictive Diseases Division - Drug Coordinator

Norma Jean Murphy
Alcohol Services Division
Department of Health and Environmental Sciences
Helena, Montana 59601

Born:	June 21, 1943 Sidney, Montana
Marital Status:	Single

Education:

9/61 - 11/62	Carroll College, Helena, Montana No degree
9/63 - 12/64	Montana State University, Billings, Montana, School of Nursing, Billings Deaconess Hospital - Associate Degree in Nursing
1/68 - 3/69	Montana State University, Bozeman, Montana, Bachelor of Science in Nursing

Work Experience:

10/74 to present	Occupational Consultant Alcohol Services Division State Dept. of Health & Environmental Sciences, Helena, Montana
3/73 - 12/73	Clinic Nurse Supervisor Glasgow Air Base, Comprehensive Health Center, Glasgow Air Base, Montana
9/69 - 3/73	Community Mental Health Nurse II Eastern Montana Regional Mental Health Center, Glasgow, Montana
9/66 - 1/68	Evening Supervisor Community Memorial Hospital Sidney, Montana
5/66 - 9/66	Montana State Hospital, Warm Springs, Montana. Staff Nurse, Receiving Hospital
9/65 - 5/66	St. Patrick's Hospital, Missoula, Montana; Float on critical areas and electro-convulsive therapy out-patient dept. for Dr. Hogan and Dr. Lewis.
12/64 - 9/66	Montana State Hospital Staff Nurse, Receiving Hospital

SECTION 14

14.1 ADDENDUM

Alcoholism Programs Of Montana, Inc.

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June 1, 1976

RECEIVED
JUN 4 1976
STATE DEPT. OF INSTITUTIONS

Dr. Robert Mattson, Director
Department of Institutions
Capital Station
Helena, Montana 59601

This organization wishes to go on record concerning the "State Plan", as follows:

1. Our knowledge of such a plan is limited to a verbal presentation by Mr. Mike Murray. (May 27, '76)
2. We do not feelthere is or ever has been a state plan, as such. Rather we feel their is a compliance document to acquire federal funds.
3. Since funding for the immediate future is crucial, we support the existing document with the understanding that this organization will be a viable part of the planning process before the fact, in future planning efforts.
4. We strongly oppose the utilization of existing Regional Mental Health Boards to accomplish regionalization. Specifically, there is a high risk of loss of Alcoholism program identity and autonomy which will result in a definite loss of client effectiveness and a general detrimental effect to the field of alcohol abuse and alcoholism, in the State of Montana.

We are aware that funding for the next fiscal, federal deadlines and other priority items have necessitated some short cutting of the planning process. However, we are vitally interested in being a part of the planning process, before the fact. Thank you.

Sincerely,

Harold Schutt

Harold Schutt
President

HS/rlw

cc: Mike Murray
Danny Peresini